Joint Legislative Audit Committee

OFFICE OF THE AUDITOR GENERAL

California Legislature

September 7, 1977

The Honorable Speaker of the Assembly
The Honorable President pro Tempore of the Senate
The Honorable Members of the Senate and the
Assembly of the Legislature of California

Members of the Legislature:

Mr. Carlyle Brakensiek, General Counsel of the Assembly Committee on Finance, Insurance and Commerce, has requested that the Joint Legislative Audit Committee provide his committee with certain information regarding that Committee's June 20 and 22, 1977 hearings on our Report 292, Department of Insurance.

In response to earlier inquiries, the Auditor General had prepared materials to be submitted on the second hearing day. However, the Committee did not pursue several of its previous questions and some material was not offered (a schedule of the procedural discrepancies involved in each of the cases cited on page nine of the Report). Enclosure number 1 is a copy of that material, with an additional column and accompanying notes.

At the close of the hearing, the Committee requested a response to the materials presented by Ms. Angele Khachadour, Chief of the Legal Division, Department of Insurance, regarding the cases described in Appendix B of Report 292. Enclosure 2 responds to that request. It is organized according to the chronology of events. Each case described in Report 292 is followed by the Department's response during the hearing, which in turn is followed by the Auditor General's response as requested by the Committee.

Mr. Brakensiek also requested additional information. Enclosure 3 is a copy of one of the two letters from licensees. (Reference to the licensee's identity have been deleted to protect confidentiality.) The other letter is included in Report 292 (Appendix D, page D-1). Mr. Brakensiek also requested any information regarding certain individuals' concern for their personal safety. He referred to ". . .the

substance of your report that two outside sources voiced concern over their personal safety and that one had received threatening phone calls." However, reference to such concerns was not included in Report 292 since their validity had not been independently corroborated. At the hearing it was related what had been told auditors to help characterize the apparent circumstances surrounding this audit. Fortunately, the two sources independently testified at the hearing. Should the Committee require further testimony, those individuals should be contacted.

The Assembly Committee on Finance, Insurance and Commerce is to be commended for its diligence in investigating the findings of the Auditor General. More often than not, policy committees lack sufficient staff and the investigative capability to follow-up on audits of the Office of the Auditor General. Audit findings and department contradictions are thus left in limbo without further public enlightenment.

Respectfully submitted,

MIKE CULLEN
Chairman

ENCLOSURE INDEX

Table 3

Penalty Reductions

Licensee	Disciplinary Penalty: Formally Specified or Ordered	Disciplinary Penalty: Amended by Licensee and Accepted by Department	Nature of Procedural Deviation (See notes below)
Agency A	$ 10,000	$ 5,000	Note 1
Agency B	$ 1,431	$ 286.25	Note 1
Insurer A	$ 12,500	$ 4,165	Note 3
Insurer B	$125,000	$62,500	Note 3
Insurer C	$187,960	$40,000	Note 3
Insurer D	$ 37,500	$12,430	Note 3
Insurer E	$ 70,000	$35,000	Note 3
Insurer F	$ 60,000	$30,000	Note 3
Insurer G	180 days*	90 days*	Note 1
Insurer H	365 days*	90 days*	Note 1
Insurer I	365 days*	305 days*	Note 1
Insurer J	180 days*	150 days*	Note 2
Insurer K	365 days*	180 days*	Note 1
Insurer L	365 days*	180 days*	Note 1
Insurer M	365 days*	120 days*	Note 1

Note: (correspond to numbered categories on report page 8)

1. Penalty reduced after a formal settlement (Special Notice of Defense) had been offered to the licensee.
2. Penalty reduced after licensee had already signed his agreement to a higher penalty.
3. Penalty reduced after final disciplinary order had been issued.

*Period of suspension of insurer's privilege to appoint temporary agents.

Analysis of Written Explanations
by the Department of Insurance
of the Handling of Selected Cases

Attached to Report 292 was Appendix B, a description of notable cases intended to exemplify some of the problems and effects discussed in the Report text.

At the close of the Committee's two-day hearing on the Report, the Department of Insurance submitted its detailed written explanations for the handling of the first 11 (of 12) cases enumerated in Appendix B.

We cannot fully evaluate the merits of these explanations because they are largely uncorroborated. The Department admitted in the hearing to the unusual lack of file documentation to support the Department's subsequent explanations. Without adequate corroboration, the explanations provided by the Department can only be regarded as suppositions.

The following pages include (1) the Appendix B case description, (2) the Department's response, and (3) a summary analysis of the major contentions raised in the Department's written explanation.

Report 292
Appendix B

Case 1

In 1975, investigation determined that an unlicensed out-of-state insurance agency transacted at least $296,000 in insurance agency premiums in California, which resulted in at least $89,800 in commissions. The agency claimed ignorance of the need to be licensed with the Department, even though the agency sold insurance in 35 other states and had a licensed California accomplice.

The Department's Legal Division formally offered a $10,000 penalty settlement, but the accused, represented by the law firm of a former insurance commissioner, was permitted to reduce the penalty to $5,000. The casefile indicated no rationale for permitting a penalty reduction. In addition, the Legal Division cleared the accused's application for an unrestricted agency license. No restrictions were placed on the licensee of the California licensee accomplice.

Report 292
Appendix B

Case 2

In contrast to Case 1, another investigation in 1975 disclosed that an out-of-state agent had attempted to sell five consumers insurance policies which had not been approved for sale in California. When the agent discovered his actions might be legally questionable, he promptly returned all documents and payments to the consumers and no insurance was ever issued.

The Legal Division offered the accused no special deal, and pursued the case to public hearing, whereupon the accused's licenses were revoked and an application for another license was denied.

Department's Response
Appendix B - Cases #1 and 2

Case #1: Agent transacted insurance in California through a licensed insurance agent. Action was taken because agent should have known that a nonresident license was necessary. The program was lawful, and there were no other improprieties involved. In fact, there was no reason whatever why agent should not have become licensed. The licensing of a nonresident agent requires the filing of a application and payment of a fee. Therefore, the fact that the agent was not licensed did not in this instance harm the public or in any way raise any question about the validity of the coverage sold. There was absolutely no impediment to this organization being licensed, and in fact the license was processed in just a few days. Both the staff counsel handling the case and the Bureau Chief were satisfied that the $5,000 fine was sufficient penalty even though initially the staff counsel had suggested $10,000. Under the circumstances, even the $5,000 fine appears to be a rather severe penalty. The agent was represented by a member of Mr. Barger's lawfirm although he at no time was involved in the discussion with the staff counsel regarding this case. The reduction of the fine was approved by the Bureau Chief in the normal course of work, and he was satisfied that it was an appropriate reduction. Comment was made that the case file does not show a rationale for permitting the penalty reduction. Both the staff counsel and the Bureau Chief at different times met with the agent's counsel to discuss what appropriate action could be taken. Since the case did not involve any deliberate avoidance of the law or the use of any unlawful scheme, the Bureau Chief himself suggested the reduction to $5,000.

Case #2, however, presents an entirely different set of facts. It involved a nonresident licensed agent who wished to place insurance in California and other states through a nonadmitted (unlicensed) insurance company. The coverage the agent wished to sell consisted of disability insurance, which in this instance cannot under California law be exported to an unlicensed insurance company. To get around the legal prohibition against exportation of that kind of business, agents set up a fictitious association in another state to which a group policy could be issued, thereby enabling agents to provide coverage thereunder to any resident of other states who wish to participate in the program even though the program itself was unlawful in California and was being provided by an unlicensed insurer. The matter was taken to hearing, and the hearing officer made the determination that it was an unlawful scheme and recommended the revocation of agent's licenses. The revocation of the licenses was a proper penalty in this case since the scheme involved was not only unlawful but would ultimately have defrauded many California residents who would have innocently bought this insurance, not realizing that neither the program nor the insurer were approved in

California. The file also shows that the program was not even approved in the state of residence of the unlicensed insurer. The hearing officer further found that the agent was not interested in retaining his California license since he could always sell insurance in California for nonadmitted insurers through a surplus line broker. Although this is true, this program could not have been thus sold in California at any rate since it was not an exportable line of business.

These two cases are factually totally unlike and the comparison made by the auditor is inappropriate and invalid.

NOTE:

Additionally, agent in Case #2 has continued to provide coverage which he describes as a "self-insured MET" to California residents and refuses to pay claims as evidenced by attached letter.

BLANKET ACCIDENT MEDICAL EXPE... ...ACCIDENTAL DEATH BENEFITS

Angle Kracka
Inc.

...13056 • SPOKANE, WASHINGTON 99213
EAST 7202 SPRAGUE AVE., SUITE D • SPOKANE, WASHINGTON 99206
AREA CODE 509 - 924 7500

March 27, 1977

SUBJECT: CALIFORNIA CLAIMS INCURRED PRIOR TO DECEMBER 1, 1976

ERISA

Dear Member:

It is difficult to explain to persons that we have had as members for 8 to 12 years why we withdrew our voluntary offer to pay those claims that are the obligation of the National Multiple Employers Foundation that recently filed Bankruptcy, but I will try.

The State of California appears to be doing all it can to do away with all Self-insured Multiple Employer Trusts since the Foundation filed Bankruptcy, yet they make no mention of the number of Life Insurance Companies that have gone into the hands of receivers due to poor management. This, therefore, proves that being under State control is no guarante that your medical coverages will pay off when you need it.

The California Insurance Department is conducting some sort of investigation on our Trusts but will not even acknowledge our Attorney's letters requesting information as to the nature of their investigation. We have been in the group insurance business for over 20 years and have operated in the State of California for 15 of those years; and I feel that we have a right to know what, if any, California laws we may have violated.

The main issue that they will not admit as the underlying factor of their attitude toward Self-insured Trusts is that we fall in the same category as Blue Cross-Blue Shield, the State does not get a premium tax.

Since there is a remote possibility that the State of California (the only State out of 15 that we operate in) can cause us to withdraw from the State, it would not be a prudent decision on the part of the Trustees to pay out additional benefits without some guarantee that our members will remain with us so that our Fund could recoup those extra benefits paid out.

We have received a number of letters from our members that have called the California Insurance Department and the investigators assigned to our Trust. It is amazing the number of derogatory remarks that are being made about us. The California Claim Investigatic Department as well as all of the other States in which we operate have hardly heard of us all these years due to our well defined benefits, our guarantee issue concept, and service

The California Insurance Department has not said we could not pay claims on the Bankrupt Foundation, they have said NOTHING at all to us but have made many derogatory statements to our California Agents and to many of our Members. We would appreciate a letter from you if you should contact one of the investigators, Ms. Karen Fetherson in the San Francis office.

Chairman of the Board of Trustees

Appendix B-2. D2

Auditor General's Analysis

Case 1

The Department contends that this case did not involve a deliberate avoidance of the law, and that the illegalities resulted from an apparent clerical error. The Department does not challenge the fact that this explanation is not documented in the case file. The Department also does not explain its rationale for imposing even a $5,000 fine on the supposed victims of clerical oversight.

Case 2

The Department's explanation of this case underlines rather than erodes the description in Appendix B of the Report. Like Case 1, the illegality was unlicensed or unapproved insurance transaction. Like Case 1, no apparent harm was caused to consumers. However, unlike Case 1, the file in Case 2 documented the mitigating circumstances. We do not pretend to judge the merits of the penalty imposed after a disciplinary hearing was held, but we do question the uniformity of the Department's procedure compared with that in Case 1. We would also suggest that the Department's citation of a pending investigation is irrelevant and inappropriate, since the licensee has apparently not been charged, let alone found guilty.

Case 3

In 1973, a former employee of an insurance agency reported to the Department about 230 insurance policies sold by unlicensed employees of the agency. Investigation confirmed the agency's systematic, intentional practice of encouraging sales by unlicensed employees. The agency had also charged at least $37,848 in illegal monthly service fees on insurance premiums. The agency had also required membership in a union before insurance could be purchased, in violation of a warning letter issued by the chief of the Legal Division three years before (although the warning letter was not included in the file for review by the investigators.)

Before the investigation had been completed, the chief of the Legal Division drafted a proposed accusation and mailed it to the accused's attorney, who is a former chief deputy commissioner. In the following five months, the chief of the Legal Division and the former chief deputy commissioner met and exchanged six drafts of proposed action. These negotiations resulted in the following:

- Deletion of factual matters questioned by the former chief deputy commissioner acting as attorney for the accused

- Addition of mitigating statements which appear to conflict with the prior Department warning

- Settlement of the case by stipulation, requiring no public access to the evidence

- Penalty of $10,000 (in Lieu of a 90-day suspension), required restitution of the $37,848 illegal fees, and promises of compliance with Department-approved procedures and agent training.

Investigation also suggested the probability of systematic training of agents to misrepresent policies to insureds, but the Department did not attempt to investigate beyond the actions of selected agents, one of whose license has already been revoked for such misrepresentation. Several other complaints of misrepresentation by other agency employees were closed "no violation" solely on the basis of the agency's promises of restitution and future compliance.

Investigators never visited the agency's Los Angeles headquarters to review its operations or files, despite recommendations of some investigators to follow up on evidence of bounced checks, which might indicate a shortage in the agency's premium trust account. In March 1977, the agency volunteered the information that it was at least several hundred thousand dollars short in its trust account.

Some aspects of the case were investigated by the Investigation Bureau's Sacramento office, but were not

formally reported through normal procedures, and incomplete investigation materials were just forwarded to Legal Division attorneys.

The Los Angeles City Attorney requested that the Department furnish certified copies of its records of the case for the purpose of criminal prosecution. The chief of the Legal Division denied this request on the basis of her skepticism that the City Attorney would actually prosecute. Insurance Code Section 12930 requires the Department to provide such records for the purpose of criminal prosecutions.

Since the settlement of the case, the Department received a number of complaints indicating violations of the settlement agreement and further misrepresentations in insurance sales. The Investigation Bureau documented some of the violations, but no action was taken. In October 1976, a Legal Division attorney issued a formal accusation on charges of fraud, forgery, and unlicensed sale to one consumer. The chief of the Legal Division rescinded the accusation, supposedly because the insurer might be willing to pay a claim based on the agent's sales misrepresentations rather than on the actual policy. No further action has been taken against the agency or its agents.

The investigation of this matter began in 1973, and the original report of investigation dated August 12, 1974, was forwarded to Legal Division on August 22, 1974. Therefore, the statement on Appendix B-3 that action was taken "before the investigation had been completed" is inaccurate. The attorney assigned to the case did not, however, proceed immediately to plead the case because Investigation advised that more complaints were being received and supplemental reports would be submitted to Legal. Additional facts and reports dated March 19, 1975, April 3, 1975, and May 19, 1975, were received. Respondents throughout 1974 had been represented by an attorney located in San Francisco; and since their main operation was in Los Angeles, they changed counsel. That attorney (Harry O. Miller) requested meetings with the staff of the Department, alleging continued deliberate harassment by the Investigation Bureau. Such a meeting was held in 1975, and in the absence of the counsel initially assigned to the case another attorney was directed to participate in the discussions. Shortly thereafter, the Chief of Legal received a request from respondent's counsel for a meeting on the grounds again that the Department's employees were being grossly unfair to his clients and were not conducting themselves in an appropriate manner. The Chief of Legal then consented to discuss the matter with respondent's counsel, which resulted in a general discussion of the various violations of law which were alleged against his clients and the manner in which these problems could be resolved. During that discussion it was pointed out that respondents had known for some time that the charge of separate fees in addition to insurance premium was considered by the Department of Insurance to be unlawful and that there was no excuse for the charges being made after notice of their illegality had been brought to their attention. In an effort to mediate what had become a very difficult case with constant charges and countercharges being made by the Department staff and respondent's counsel of improprieties on both sides, the Chief of Legal did agree to recite all of the charges which would be made against respondents and submit this to counsel for comments. This was done by means of the draft of an accusation. It is not true that the Chief of Legal Division drafted the proposed accusation as stated by auditor on appendix B-2 #3. The accusation was drafted by the counsel handling the case and was reviewed by the Chief of Legal, who mailed it to respondent's counsel by cover letter dated July 11, 1975, a copy of which is included in the Auditor General's rebuttal. The Department counsel had left for a 3 1/2 week vacation and military leave of absence and had not had the opportunity to review the dictated draft. This was done by the Chief of Legal, who forwarded it to the counsel. (Report, Exhibit C-2) The auditor also alleges that during the following five months the Chief of Legal and

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respondent's counsel, a former Chief Deputy of the Department, met and exchanged six drafts of proposed actions. That statement is not borne out by the records. The Chief of Legal has no independent recollection as to what additional drafts may have been exchanged and recalls only having met with respondent's counsel once. The file contains a second draft of a Special Notice of Defense and Order but it was never submitted to respondents. On August 21, 1975, staff counsel forwarded a third draft of SNOD and Order and a Stipulation/Waiver and Order. Respondent's counsel in October returned his revised draft. About November 10, 1975, Chief of Legal requested advice from staff as to status of case and reviewed respondent's counsel's revisions. Staff counsel was directed to move on the case as Chief advised that she was becoming irritated with respondent's counsel and the delay in settling the matter. Staff issued an accusation. Chief advised staff counsel that a S/W&O had been intended so on November 14 an accusation was redesigned as a Stipulation/Waiver containing the same substantive charges as the Accusation and it was mailed to respondents, signed by it, and returned on January 9, 1976. Once cases are negotiated, it is not uncommon that drafts would be exchanged. It is a proper procedure, and it is equally proper to agree on mitigatory statements to be included in stipulated orders. Department counsel eventually prepared and issued an accusation dated November 14, 1975, which was mailed to respondent. This had not, however, been a proper reflection of the agreement reached with respondent's counsel; and in lieu of proceeding on the basis of the accusation, Department counsel drafted a stipulation and waiver reciting substantially all of the same facts recited in the November 14 accusation and submitted that to respondent's counsel and it was in turn signed on January 9, 1976. As a result of respondent signing this stipulation and waiver, an order was issued on January 26 and a fine of $10,000 in lieu of a 90-day suspension was received on April 27, 1976. The main thrust of this action, however, was not the fine but the order compelling respondents to refund the service fees unlawfully charged. It was eventually determined that a sum of approximately $30,655 remained to be refunded. Respondents filed a report during August of 1976 submitting evidence of the refunds made; and in accordance with the terms of the stipulation and waiver respondents paid the State of California through the Department of Insurance the sum of $6,437.20 representing that portion of the refunds which respondents could not successfully refund to the insureds entitled thereto as the payments were returned by the Post Office marked "undeliverable". It was represented to the Department that the cost of making these refunds was at the very least twice the amount of the refunds themselves. The additional investigation which the auditor suggests should have been made included matters which had taken place prior to the final action taken by the Department. It had been agreed that with the respondents agreeing to change its procedures in accordance with procedures approved by the Department and to modify its agents training to also bring that into compliance with Department directives all matters arising prior to the final order would be deemed settled. New matters arising thereafter would, however, be subject to normal investigation procedures.

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In appendix B-4 the auditor comments that despite the LA City Attorney request that the Department furnish certified copies of its records of this case for the purpose of criminal prosecution and that the Chief of Legal denied the request and that further such a request should have been granted under Insurance Code Section 12930. In its first response to the Auditor General's report (see DI-9) the Department stated that the case was not certified to the City Attorney because the evidence available to the Department would not support a criminal action. (Insurance Code Section 12928) Further, it is stated that the Chief of Legal met with the City Deputy Attorney to discuss the case and was advised that criminal action was not contemplated but that rather a civil action to impose a fine penalty was the attorney's objective. In rebutting that statement, the auditor has attached as exhibit C-4 a letter from the Deputy City Attorney dated June 30, 1970, indicating that the records were requested for the purpose of possible prosecution of alleged misdemeanor conduct. That letter cannot serve as a rebuttal to our comments since the letter was the original formal communication to this Department and the meeting the Chief of Legal had with the Deputy City Attorney took place subsequent to that letter. It was at that meeting that it was established that there was no intention to take criminal action but to subject the respondents to a fine. It is believed that a statement can be secured from the City Attorney establishing the fact that criminal action was never seriously contemplated and that further the file would not have supported criminal prosecution. There was no basis under Section 12928 on which to turn over records of the Department.

Again it should be pointed out that although the auditor cites Insurance Code Section 12930 he fails to mention the circumstances under which that section becomes operative; i.e., if under Section 12928 the Commissioner ascertains that a violation of the Penal Code has been committed he must then certify the matter to the District Attorney. The relationship of these two sections and the burden placed on the Commissioner to make certain that a criminal act has taken place before certifying it to a law enforcement agency was discussed at length with Mr. Tacy.

STATE OF CALIFORNIA

DEPARTMENT OF INSURANCE

In the Matter of the Insurance Licenses and Licensing Rights of [redacted] Respondents.	O R D E R File No. SF 11620-AP SF 11633-AP SF 11808-AP

[redacted], having stipulated to the entry of this Order and with good cause appearing, IT IS ORDERED:

I

Respondents shall, within thirty days after the effective date of this Order, submit to said Insurance Commissioner for his approval, a procedural manual to control the manner in which Respondents enter into Agent Agreements in the State of California. Said procedural manual, at a minimum, shall comply with the provisions of the California Insurance Code, the regulations promulgated thereunder, and the terms and conditions of this Order.

II

Respondents shall, within sixty days after the effective date of this Order, review each and every policy file on policies issued during the five years immediately preceding the effective date of this Order and shall develop a listing of each policy on which a "service fee" was charged, the name of the insured, the current address of the insured, and the aggregate amount of service fees charged upon each policy. Respondents shall, within ninety days after the effective date of this Order, deliver to the insured referred to hereinabove, the

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#3

aggregate amount of service fees charged together with a statement which contains the following language:

"The California Insurance Commissioner has determined that you are entitled to a full refund of all service fees charged on any policies of insurance obtained through [redacted] The remittance contained herein represents the total amount of service fees changed by [redacted] according to our records. If this is not an accurate remittance, please notify, in writing, [redacted], Lynwood, California 90262." Respondents shall, within 120 days after the effective date of this Order, provide to the California Insurance Commissioner the listing described hereinabove and said listing will be supplemented with notations to show which service fees have or have not been refunded as specified hereinabove. Any service fee not refunded shall be delivered to the California Insurance Commissioner as a monetary penalty pursuant to the provisions of California Insurance Code Section 1748.

III

Respondents shall establish a Policyholders Complaint Bureau which shall be supervised by a person licensed to act as a life and disability agent in the State of California. Said Policyholders Complaint Bureau shall direct the collection, analysis, and resolution of all policyholder complaints received from or originated by past, present or future insureds under policies of insurance transacted by any person described in paragraph V hereinbelow. The Department may send copies of any complaint received concerning the persons described in paragraph V hereinbelow to the person about which the complaint is made, and within thirty days after receipt of the complaint the Policyholders Complaint Bureau shall report its handling of the complaint in writing to the Department of Insurance of the State

of California. One of the purposes of this order is to make certain that Respondents establish the necessary control and maintain a competent and sufficient staff to fully protect the interests of the insured public with whom it deals. To that end, the Department of Insurance may at any time examine the books and records of Respondents to analyze complaints received by Respondents and the manner in which Respondents are discharging their duties to determine whether the inadequacies of Respondents administrative operations have been corrected. This procedure shall not preclude the Insurance Commissioner from commencing disciplinary action for any violation of the California Insurance Code discovered as a result of the procedure described herein.

IV

Respondents' licenses and licensing rights in the State of California shall be suspended for a period of 90 days commencing one hundred days after the effective date of this Order unless Respondents pay a monetary penalty in the amount of $10,000 to said Insurance Commissioner pursuant to the provisions of California Insurance Code Section 1748, on or before the ninetieth day after the effective date of this Order.

V

The terms and conditions set forth herein shall apply to Respondents individually, and severally, and to any other California insurance license or licensing right held by and to any organization holding any license issued by said Insurance Commissioner upon which is a named transactor or or any person acting on his behalf is an officer, director, employee, agent, trustee or control person.

VI

The California Insurance Commissioner may again raise any matter contained in the stipulation and Waiver entered by

Respondents in the above-entitled matter whenever the California Insurance Commissioner believes Respondents have failed to comply with any provision of this Order.

VII

This Order is a disposition of the matters contained in the Stipulation and Waiver served upon Respondents in the above-entitled matter and is not a disposition of any other matter that may or will be pending between the Respondents and the California Insurance Commissioner.

This Order shall be effective on the date set forth hereinbelow.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal this 21st day of January, 1976.

WESLEY J. KINDER
Insurance Commissioner

By Angele Khachadour
ANGELE KHACHADOUR
Deputy

STATE OF CALIFORNIA

DEPARTMENT OF INSURANCE

In the Matter of the Insurance Licenses and Licensing Rights of _____ Respondents.	STIPULATION AND WAIVER File Nos.

NOW COME THE RESPONDENTS NAMED HEREINABOVE, AND STIPULATE AS FOLLOWS:

I

Respondents hereby acknowledge the jurisdiction of the California Insurance Commissioner, waives Accusation, Notice of Hearing, Hearing, and any and all procedural rights accorded Respondents under the California Insurance Code and the Government Code of the State of California, admits the facts contained hereinbelow, and that these matters constitute sufficient grounds for said Insurance Commissioner to enter the Order, a copy of which is attached hereto.

II

hereinafter, now is, and at times mentioned herein, has been licensed by said Insurance Commissioner to act as an organizational life and disability agent, and as an organizational disability only agent in the State of California.

III

hereinafter, now is, and at all times mentioned herein, has been licensed by said Insurance Commissioner to act as an organizational insurance agent, organizational disability only agent, and as an organizational life and disability agent.

IV

now is, and since March 6, 1974, has been licensed by said Insurance Commissioner to act as an organizational life and disability agent in the State of California.

V

_____

hereinafter "Respondents", now are, and at all times mentioned herein, operated under the direction and control of with corporate offices located at Lynwood, California.

V-A

has not committed any of the acts with which Respondents are charged pursuant to this Stipulation, and is named as a Respondent solely because it is under joint control and direction with AREA- for purposes of this Stipulation and the Order on which this Stipulation is based.

VI

Respondents, during the years 1973 and 1974, in California, transacted life and disability insurance and paid commissions thereon to:

Said commission payments were made at a time when the above-named individuals were not licensed by said Insurance Commissioner to

transact life and disability insurance in the State of California and all said transactions were made in violation of California Insurance Code Sections 1631 and 755.

VII

Respondents, during the years 1969 through and including 1975, in California, entered into agreements with employee associations and unions for the purpose of obtaining access to payroll deduction slots held by said employee associations and unions and agreed to pay to said employee associations and unions $1 per month per insured accepted by said employee associations and unions as associate members eligible for payroll deduction of insurance premiums. Thereafter, Respondents did solicit individuals to obtain policies of life and disability insurance through Respondents and arranged for said insureds to become associate members of said employee associations and unions, and did arrange for the payment of insurance premiums through payroll deduction slots of said employee associations and unions, and did charge and collect $1 per month from each such insured, and did remit said $1 to said employee associations and unions. Said employee associations and unions were not licensed by said Insurance Commissioner in any capacitiy to act as life and disability agents and the payment of said $1 associate membership fee per month was made in violation of California Insurance Code Section 755.

VIII

Respondents, during the years 1973, and 1974, and 1975, in California, charged and collected an unlawful "service fee" in the amount of 50 cents per month from many insureds holding a policy of life and disability insurance issued through Respondents. The aggregate amount of unlawful "service fees" collected by Respondents is not less than $37,848. Said Insurance Commissioner on or about May 9, 1974, informed Respondents that "service fees" were collected in violation of Section 1730 of

said Insurance Code, but thereafter Respondents continued to collect said "service fees". As of the date hereof, Respondents have failed to refund any portion of said unlawful "service fees".

IX

Respondents, during the years 1974 and 1975, in California, received instructions to cancel policies of insurance and to cancel payroll deductions from

s. Thereafter, Respondents failed and neglected to cancel said policies of insurance or payroll deductions in a timely manner.

X

The matters hereinabove set forth in paragraphs VI, VII and VIII show that Respondents have failed to perform a duty expressly enjoined upon Respondents by a provisions of said Insurance Code or has committed an act expressly forbidden by a provisions of said Insurance Code and constitutes sufficient grounds for said Insurance Commissioner to suspend or revoke any and all insurance licenses and licensing rights issued to Respondents pursuant to California Insurance Code Sections 1668 (1) and 1738. .

XI

The matters herinabove set forth in paragraphs VI, VII, VIII, and IX, show that Respondents have demonstrated incompetency or untrustworthiness in the conduct of any business, or have by commission of a wrongful act or practice in the course of any business exposed the public or those dealing with Respondents to the danger of loss and constitutes sufficient grounds for said Insurance Commissioner to suspend or revoke any and all insurance licenses and licensing rights issued to Respondents pursuant to the provisions of California Insurance Code Sections 1668 (j) and 1738.

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XII

Respondents, in mitigation, offer the following:

(a) At no time prior to the filing of this Stipulation and Waiver did the Department officially notify its licensees that the matters alleged in Paragraph VII constituted a violation of the California Insurance Code.

(b) Service fees were collected from many but not all insureds and the exact amount is unknown to Respondents at this time. Respondents did not collect service fees on policies written after May 9, 1974, after being informed by the California Insurance Commissioner that the practice of charging service fess violated provisions of the California Insurance Code, but did not cease collecting service fees on policies written prior to May 9, 1974 until January 10, 1975 due to the normal lead time necessary to delete service fees.

Respondents declare the above to be true under penalty of perjury and execute this document at Sherman Oaks, California on this 9 day of January, 1976.

STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE

In the Matter of the Insurance Licenses and Licensing Rights of [redacted], Respondents	ACCUSATION File Nos.

The Insurance Commissioner of the State of California in his official capacity alleges that:

I

hereinafter, now is, and at times mentioned herein, has been licensed by said Insurance Commissioner to act as an organizational life and disability agent, and as an organizational disability only agent in the State of California.

II

hereinafter, now is, and at all times mentioned herein, has been licensed by said Insurance Commissioner to act as an organizational insurance agent, organizational disability only agent, and as an organizational life and disability agent.

III

now is, and since March 6, 1974, has been licensed by said Insurance Commissioner to act as an organizational life and disability agent in the State of California.

IV

Hereinafter "Respondents", now are, and at all times mentioned herein, operated under the direction and control of with corporate offices located at Lynwood, California.

V

Respondents, during the years 1973 and 1974, in California, transacted life and disability insurance and paid commissions thereon to:

Said commission payments were made at a time when the above-named infividuals were not licensed by said Insurance Commissioner to transact life and disability insurance in the State of California and all said transactions were made in violation of California Insurance Code Sections 1631 and 755.

VI

Respondents, during the years 1969 through and including 1975, in California, entered into agreements with employee associations and unions for the purpose of obtaining access to payroll deduction slots held by said employee associations and unions and agreed to pay to said employee associations and unions $1 per month per insured accepted by said employee associations and unions as associate members eligible for payroll deduction of insurance premiums. Thereafter, Respondents did solicit individuals to obtain policies of life and disability insurance through Respondents and arranged for said insureds to become associate members of said employee associations and unions, and did arrange

for the payment of insurance premiums through payroll deduction slots of said employee associations and unions, and did charge and collect $1 per month from each such insured, and did remit said $1 to said employee associations and unions. Said employee associations and unions were not licensed by said Insurance Commissioner in any capacity to act as life and disability agents and the payment of said $1 associate membership fee per month was made in violation of California Insurance Code Section 755.

VII

Respondents, during the years 1973, 1974 and 1975, in California, charged and collected an unlawful "service fee" in the amount of 50 cents per month from many insureds holding a policy of life and disability insurance issued through Respondents. The aggregate amount of unlawful "service fees" collected by Respondents is not less than $37,840. Said Insurance Commissioner on or about May 9, 1974, informed Respondents that "service fees" were collected in violation of Section 1750 of said Insurance Code, but thereafter Respondents continued to collect said "service fees." As of the date hereof, Respondents have failed to refund any portion of said unlawful "service fees."

VIII

Respondents, during the years 1974 and 1975, in California, received instructions to cancel policies of insurance and to cancel payroll deductions from

[redacted] and from other insureds. Thereafter, Respondents failed and neglected to cancel said policies of insurance or payroll deductions in a timely manner.

IX

The matters hereinabove set forth in paragraphs V, VI and VII show that Respondents have failed to perform a duty expressly enjoined upon Respondents by a provision of said Insurance Code or has committed an act expressly forbidden by

a provision of said Insurance Code and constitutes sufficient grounds for said Insurance Commissioner to suspend or revoke any and all insurance licenses and licensing rights issued to Respondents pursuant to California Insurance Code Sections 1668(1) and 1738.

X

The matters hereinabove set forth in paragraphs V, VI, VII, and VIII, show that Respondents have demonstrated incompetency or untrustworthiness in the conduct of any business, or have by commission of a wrongful act or practice in the course of any business exposed the public or those dealing with Respondents to the danger of loss and constitutes sufficient grounds for said Insurance Commissioner to suspend or revoke any and all insurance licenses and licensing rights issued to Respondents pursuant to the provisions of California Insurance Code Sections 1668(j) and 1738.

DATED: Nov. 14, 1975

WESLEY J. KINDER
Insurance Commissioner
By Philip R. Hinderberger

PHILIP R. HINDERBERGER
Counsel

Auditor General's Analysis

Case 3

The Department's lengthy explanation of this case is at substantial variation with that in Appendix B only on questions of interpretation. For example, the Department first takes issue with Appendix B's assertion that the Department mailed the licensees' attorney a draft accusation before the Department's investigation had been completed. Our primary source for that statement was the cover letter attached to that draft accusation; the letter is reproduced on page C-2 of Report 292. The Department contends that opening such negotiations was justified in part by the continuing receipt of complaints against the licensees' agents, so that the Department might add subsequent charges. The Department does not explain why this procedure was preferable to issuing formal charges--to be amended if necessary. This question is amplified by the fact that no new charges were added as a result of the interchange of the six drafts of pleadings. The Department concedes that it engaged in extraordinary negotiation of draft charges in this case. Supposedly, these negotiations were undertaken because of the licensees' charges of the Department's unfair investigations of the issues. We recall no evidence in the casefile to document these charges, let alone an explanation of their relevance to the extended negotiations of the disciplinary issues against the licensee.

Case 4

Examples #4 (a) through (s) represent the entire file of public complaints and disciplinary actions against one insurance agent through 1976. All investigations and legal actions were approved through normal supervisory review. A total of 11 investigators handled one or more of these cases out of the San Francisco office. Eight of these investigators are still in the Bureau.

a. The complaint file was opened in 1969, when investigation of a complaint indicated that the accused agent had illegally diverted at least twenty clients from her employer to another agency. After leaving that employment, the agent sold insurance without proper license. Once the Department began investigating the complaint by her former employer, she applied for an agent's license.

In the opinion of the staff attorney (now chief of the Legal Division) to whom the violations were referred, the accused's license application would have to be denied unless the accused at least admitted guilt. The attorney was also concerned about pressure from a legislator's office to clear the license application. The attorney later changed her mind, and in May 1969 the accused was issued a restricted license without having to admit guilt to any violations.

4 (b) - (s)

b. In 1970 the Department reprimanded the licensee for selling insurance outside her license between May and August 1969. The Department accepted as mitigation a supposed oral agreement between the licensee and an insurer effective July 1969.

c. In 1970, the Investigation Bureau received a complaint of the licensee selling outside her license through another licensee. The investigator (now chief investigator) closed the case informally because the Legal Division was granting her a license to cover the kind of activity not covered by her previous license.

d. In 1973, the Investigation Bureau received a complaint of the licensee selling outside her license. The case was closed informally despite the licensee's admission to the allegation.

e. In 1973, Investigation Bureau received a complaint of the licensee's failure to return a premium. The case was closed informally on the basis of the licensee's denials, despite the investigator's acknowledgment of no evidence to support her statement.

f. In 1973, the Investigation Bureau received a complaint of the licensee selling an insured the wrong policy. The case was closed "no violation" on the basis of the licensee's secretary's statements without seeking corroboration in the licensee's files.

g. In 1974, the Investigation Bureau received a complaint of the licensee's unjustified cancellation of an insured's policy. The case was closed "no violation" on the basis of the licensee's description of events without seeking any corroboration.

h. In 1974, an insurance company informed the Department that the licensee might have a shortage in her premium trust account. The Investigation Bureau did not audit her trust account, but did warn her not to use unauthorized business titles.

i. One month after the warning letter was sent in case 4(h) the same investigator received correspondence from the licensee showing continued use of the unauthorized business titles. The investigator took no action on the violation of his warning letter. (Licensee had yet to comply with this technical matter as of March 1977.)

j. In 1974, the Investigation Bureau received a complaint that the licensee had incorrectly advised the insured of the necessity for special insurance coverage. The Case was

closed "no violation" after the licensee blamed the insurance company for giving her bad advice. The case file did not include any substantiation for the licensee's statement, and no investigation was made of potential misrepresentation by the insurance company.

k. In 1974, the Investigation Bureau received a complaint of the licensee's failure to notify insured of policy cancellation until after an insurance claim had been filed. The case was closed "no violation" on the basis of the licensee's lack of records. (Insurance Code Section 1747 permits the Department to seek revocation if a licensee's records are not brought up to standard within sixty days after a formal Department warning.)

l. In 1975, the Investigation Bureau received a complaint of the licensee selling a policy from a company the insurer did not want. The case was closed informally despite the licensee's admission of no records, and documentation from the insurer of a possible violation by the licensee.

m. In 1975, the Investigation Bureau received a complaint of the licensee selling a consumer a policy he did not desire. The case was closed "no violation" on the basis of the licensee's explanation despite a lack of records to document her explanation.

n. In 1975, the Investigation Bureau received a complaint of the licensee's failure to refund an insured's premium down payment. The case was closed informally despite the licensee's lack of records to document her explanation.

o. In 1975, the Investigation Bureau received a complaint of the licensee accepting a premium for insurance but not securing a policy or returning the premium to the consumer until after the consumer filed an insurance claim. The case was closed "no violation" despite the licensee's lack of records.

p. In 1975, the Investigation Bureau received a complaint alleging that the licensee sold a consumer the wrong type of policy. There is no record in the file of any investigation of this complaint.

q. In 1975, the licensee complained to the Investigation Bureau that an insurer was replacing her as broker of record on some policies. The case was closed with a warning to the licensee to remit any premiums collected on such business. However, the file includes no record of inquiry to the insurer regarding its justification for replacing the licensee as broker of record.

r. In 1976, the Investigation Bureau received a complaint of the licensee overcharging for the insured's coverage. The case was closed informally after the insured was given a refund. The investigator reported that both the licensee

and the insurer had knowingly misrepresented the policy coverage, but no action was deemed necessary because neither was selling that type of policy anymore.

s. In 1976, the Investigation Bureau received a complaint from the licensee that an insurer would not accept her business unless she placed it through other agents. This case was not even opened, let alone investigated to determine why the insurer refused the licensee's business or whether the licensee was illegally selling through other agents.

Case involved an employee of a licensed agent who had diverted clients from her employer to another agency for the seeming purpose of eventually acquiring those clients upon getting a license from the Department. The auditor calls attention to the fact that this file was handled by a staff attorney who is now Chief of the Legal Division and paraphrases a memorandum in the file indicating that she had given an opinion to the effect that agent (the auditor characterizes her as an accused), should at least admit guilt before a license could be issued. The auditor comments that the attorney changed her mind and issued in fact a license to this agent without having the agent admit guilt to any violation. The auditor paraphrases counsel's opinion, which is contained in a three-page analysis. The auditor, however, in stating, "the attorney later changed her mind ..." deliberately and knowingly misstated the facts which were before him. That memorandum to file showed on its face a handwritten notation which reads as follows: "Prepare statement in "nolo contendere" terms ("purported or alleged") for a restrictive license. Then please provide me with a copy for transmittal to other interested parties." That quotation was initialed and dated by the then Commissioner Barger and appears in very bold red ink which the auditor could never possibly have missed since he obviously read the memorandum. This is another instance of the auditor knowingly and willfully ignoring the evidence before him. A copy of that memorandum is attached hereto. Obviously the handwritten notation was a direct order to staff counsel to handle the matter in a manner which was inconsistent with her recommendation. Also obviously, since that directive was carried out, the auditor must have known that it was given by a superior of the attorney.

This memorandum also showed the reason this licensee was receiving considerable support and sympathy from outsiders, including legislators. This agent was a woman and black. Her employer, whose offices were in Oakland, had purchased the business in the Fillmore District and needed a black person to run it. All of the clients were black, and we knew that without their corroboration we could never prove a case against her. They were cool to the idea of testifying against her. These were the facts ignored by the auditor. Also attached is a letter to the San Francisco District Attorney's office which had inquired about the case.

State of California

Memorandum

To : File

Date April 8, 1969

From : Department of Insurance -- ANGELE KHACHADOUR
1407 Market St., San Francisco 94103

Subject:

FILE NO.
APPLICATION FOR AN AGENT'S LICENSE

1. A complaint was received on January 7, 1969 from a former employer of subject, stating that subject had during the course of her employment diverted business received at the office of her employer to other agents.

2. On the basis of the information supplied by the employer, an investigation was instigated the results of which have established to my satisfaction that subject was very likely "stealing" business from her employer in the hope of setting up her own office.

3. In light of our investigation, no new license could be issued to subject. Her attorney requested that a meeting be held with the Department although our investigation was not completed. The first of our meeting was held on January 27, 1969, three weeks after the complaint had been received. Subject was represented by her attorney, At the outset of the meeting, accused our investigator of unduly harassing his client and of acting in a manner which was indicative of bias and prejudice toward her. was intimating that this office was untertaining the complaint simply to please . and that there was no basis for the accusations made against her. was abusive and used threatening language indicating that she had friends who were able to intervene on her behalf. The undersigned made it very clear that the Department had no interest in preventing from earning here livelihood in the insurance field and that in light of the facts submitted by her employer, our Investigation Bureau had to determine whether or not . allegations were true before proceeding with her application.

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Appendix B #4a. 132

4. During this conference, story was elicited regarding several cases referred to us by her employer showing that the insurance had been placed through his office but by another agent. had totally unacceptable explanations for each of them. The undersigned offered her the list of the names submitted by employer and suggested that she submit a statement regarding each of them.

5. A week or so later, submitted a letter written by him regarding the cases referred to during our meeting. No signed statement from his client was ever received. In order to expedite this matter and to avoid possible unpleasant difficulties which might be created by subject, priority was given to this case over other cases assigned to Investigator Feinstein. A few weeks thereafter and although I was not fully satisfied with the scope of the investigation, it was decided that no further work would be done until I had an opportunity to review our findings with subject's attorney.

6. I met with on April 1, 1969 and furnished him with copies of statements taken from individuals who claimed to have applied for insurance coverage with the office of subject's former employer and were never advised that their insurance had been in fact placed by an agent unrelated to that office. These statements in my opinion are very damaging to subject's contentions that the few cases she referred to other agents were cases which her employer could not have placed or cases where the applicant could have obtained the same coverage at more favorable rates. It was my understanding that would confer with his client. During that meeting, I made the following observations to Since I was personally convinced from the evidence that was "diverting" business away from her employer, I could not stipulate to the issuance of a restricted license unless was honest enough to come forth and admit the reasons for giving business to another agent. I recognized that and her former employer must have had some personal difficulties with one another, and I was quite willing to consider any mitigatory facts which her attorney might submit. The offer to stipulate for a restricted license was based partly on our mutual desire to see . licensed as soon as possible.

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7. It was the understanding of the undersigned that had offered to sell his business to for a sum far below that which he had had to pay for it. agreed that any stipulation by would have to be made conditional to her reaching an agreement with her former employer for the purchase of the business and further that would have to forego court action for damages.

8. On April 3 or 4, a gentlemen by the name of claiming to be from the office of Senator called Mr. Wikstrom and asked him why we were forcing this woman to confess to something that she had not done and which might subject her to a law suit from her employer. Obviously, had been contacted by her attorney and had on that same day reported a distorted version of my conversation with to the Senator's office.

9. called me on the 3rd or 4th and demanded to see a copy of the complaint filed by . I politely advised him that until formal action was taken against that complaint remains confidential.

10. This morning was advised that unless this matter can be settled by stipulations, formal pleadings would be prepared by me toward the end of the current month.

Angele Khachadour

ANGELE KHACHADOUR

AK:kn

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June 9, 1969

Office of the District Attorney
880 Bryant Street
San Francisco, California 94103

ATTENTION:
Assistant District Attorney

SUBJECT :

Dear Mr.

This is in reply to your letter of June 3, 1969 requesting our reasons for granting a restricted license to Mrs. in light of the facts uncovered during our investigation. In the past, the Department has stayed clear of cases which involve a dispute between an agent or broker and his solicitor. This general policy is based on the premise that either the employer or the employee can seek redress through court action either by means of injunctive relief or damages. We have found to our great regret that in many cases of this nature the employer or the employee looks to the Department as a means of obtaining the kind of redress which he may be unwilling to pay for by retaining private counsel.

In Mr. 's case we had the added difficulty of establishing that the individuals whose applications for insurance were given to other agents had never given their consent. Although several of these individuals indicated that they believed to have been insured through the ence Agency we had good reason to suspect that, once under oath, they would very likely change their story.

It should also be noted that although Mrs. was granted the license, said license is restricted and may be revoked by the Commissioner pursuant to Section 1742 of the Insurance Code with or without cause. Our willingness to stipulate to such a restricted license was also partly based on the expectation that a hearing officer would have probably recommended the same action.

(Retyped from original document; original unsuitable for reproduction)

If you feel that I can be of any further help, please do not hesitate to write or to call. I may be reached at 557-1429.

Very truly yours,

Insurance Commissioner

BY

ANGELE KHACHADOUR
Counsel

AK/dra

(Retyped from original document; original unsuitable for reproduction)

ANALYSIS OF "NOTABLE CASES" REPORTED
IN AUDITOR GENERAL'S REPORT 292

Case No. 4, Page B-5

a. Matter handled by Legal Division Compliance Bureau. See their report for comments.

b. The mitigation was not a supposed oral agreement but documentation from the insurer (records and testimony) that they intended to appoint subject when an agent's license was issued in May 1969 but a slip up within the insurer's office kept it from happening. Five policies were involved with a commission of $178.05.

c. The complaint was not that the licensee was selling outside of license through another licensee but that a claim had not been paid in due course. The case involved the subject referring the complainant to another agent to get coverage with standard rates in a standard company rather than with her own sub-standard market which would have been at a higher rate. There was no evidence of commission split or profit to the subject. The case was closed for these reasons and not because another license was being issued. The file shows the closing was discussed with Mr. Feeley, the Department's Disciplinary Attorney at that time, prior to closing.

d. The file reveals the subject did not sell outside of license but that an insurer merely inquired if they could pay the subject a commission on a policy sold by a licensed agent after her referral. Response to the insurer was negative.

e. The file reveals the case was not closed on the basis of the subject's denials but because the subject had returned the premium to the complainant as soon as obligated to do so. The obligation to return it begins when it is received by the licensee. Documentary evidence from the insurer supported this finding.

f. The file reveals the matter was closed because there was no support for the complainant's position and after obtaining documentation from the subject's file as well as a detailed written statement from the subject as well as the secretary.

g. The file reveals the complainant only paid part of the renewal premium resulting in a cancellation for non-payment. The subject then placed the complainant with the Assigned Risk Plan and returned the unearned premium. This was not pursued further because documentation provided by the complainant supported the subject's statement.

h. Following receipt of the information from the insurer's general agent that the licensee might have a trust account shortage, inquiry was made with the general agent to obtain substantiation. They advised that they did not have reason to believe a shortage existed but that they were pressuring the subject to resolve contractual accounting discrepancies.

i. Subject was signing correspondence "President" when not incorporated. The specific correspondence referred to in the Auditor General's Report was not found but a review of correspondence in 1976 and 1977 did not confirm the subject was continuing to sign correspondence as "President".

j. The case file confirms the general agent's instructions were unclear to the subject and other agents representing them. The error was clarified by the insurer by bulletin to all agents the insurer's instructions were subject to misinterpretation but no grounds existed for misrepresentation investigation.

k. We were not able to identify this investigation from the information contained in the auditor's report.

l. The auditor's description is unclear but the file indicates the insurer desired by the complainant declined the risk. The subject advised the complainant that

it could be placed with another insurer but the complainant declined. A field warning was given concerning violation of Section 1727.

m. A review of this file indicates the licensee provided a possible explanation and supplied supporting documentation.

n. This file reveals that records did exist as to receipt of money from the complainant and no evidence was presented or developed to indicate failure to refund immediately was other than clerical oversight. No other record was required according to the elements of the transaction.

o. An investigation conducted through several sources including the subject showed that the complainant's problem arose from handling by the lender (not licensed by this Department) not from the subject. The subject had complete records of the transaction.

p. We were not able to identify this matter from the auditor's description.

q. The request to replace the subject as broker of record was from the insured to the insurer who acted in accordance with the policyholder's wishes. No other justification was required.

r. The program referred to originated with the general agent, not with the subject. After the program was started, it was found to be improper and the matter was taken up with the general agent and a disciplinary file prepared. The subject was marketing a program provided her by another source. There was no evidence of intentional wrongdoing.

s. File reveals that it was a general agent that refused to accept further business, rather than the insurer. Termination of an agreement to accept business can be done according to contract. An appointment for the

insurer remained in effect, however, and it would not be illegal for the subject to place the business through other properly licensed agents and receive commission. This is not an unusual procedure.

Auditor General's Analysis

Case 4

The Department's contention that we "deliberately and knowingly misstated" that the attorney changed her thinking is easily dismissed after reading the second paragraph of the Department's written explanation of Case 4a (page 35). The attorney's changed thinking is also detailed in her letter to the San Francisco District Attorney, whose questioning of the Department's action was presumably based on a working knowledge of the ethnic considerations in prosecuting crimes.

Case 4 (b)- (s)

The Department's chief investigator makes a number of factual contentions which conflict with the descriptions in Appendix B. No documentation was provided to support these contentions. A number of the contentions conflict with case file summaries written by the investigators and approved by their superiors.

Case 4 (i)

The chief investigator said he could not find any evidence of the technical violation cited in our description. He explained that the licensee's unauthorized use of "President" had apparently been corrected.

The violation to which Appendix B referred was unauthorized use of "General Insurance" in the licensee's business title. Attached (page 47) is a copy of a letter from the licensee which indicates continued use of the identity "General Insurance." (See upper right corner.)

Use of this term was the technical violation which the investigator, his supervisor, and now the chief investigator overlooked.

Case 4 (k) and (p)

The chief investigator said he couldn't identify these cases. For public purposes, they may be identified as:

(k) received 11/27/74, closed 3/10/75, name initials E.B.M.

(p) part of case 4 (o) file, name initials H.C.

FROM

GENERAL INSURANCE
STREET
SAN FRANCISCO, CA. 94115
367-

MARY L. W_____ LOAN NO. 1-1292333

DATE 1/30/75

Gentlemen:

Enclosed, please find copy of the Hartford policy that was mailed to your office in 1972. Also, same policy was paid by your office in 1973. Please remit the final installment now due and payable.

PS: Pursuant our telephone conversation with Mrs. W , your company should have paid the premium now due and payable in November of 1974. Policy is still enforced. Please advise.

We have ordered another certified copy of the policy for your file.

Thank you,

_____, Agent

Copy furnished by

Case 5

In 1974, an insurance company employee reported to the Department that the company had a scheme for fraudulently increasing the apparent amount of its financial reserves on workmen's compensation insurance. Investigation by the Investigation Bureau verified that the insurer's reserves were artifically inflated by 29 percent, or $8.5 million. This simultaneously reduced dividends payable to policy holders by $1.5 million. False reporting of reserves to the California Inspection Rating Bureau (CIRB) affected the setting of workmen's compensation insurance rates.

The chief of the Legal Division drafted a proposed accusation charging the comapny with willful submission of false information to the CIRB. However, the insurer was permitted to review and negotiate drafts of proposed actions by the Department, which resulted in the Legal Division 1) dropping the charge of willful violation, 2) eliminating a proposed $10,000 penalty, 3) requiring no admission of any violations, and 4) ordering the company to eliminate its artificial reserves scheme.

An investigation conducted during the fall of 1974 revealed that this insurer increased its reserves on individual open claim cases by an arbitrary factor of 29%, as a result of which the company was able to reduce dividends on its workers' compensation insurance policies by about $1½ million. These increases resulted in changing the figures which are reported by insurers to the California Insurance Rating Bureau by means of unit statistical filing reports which in turn would adversely affect the experience modification for rating purposes of the insureds involved, thereby resulting in their being charged higher premiums. The investigation had been directed by the Department's Chief Deputy because he had been the recipient of the original complaint. The case was received by Legal with a rush request for immediate action, and it was assigned to an attorney familiar generally with workers' compensation insurance.

The auditor states (B-11) that the Chief of Legal drafted a proposed accusation charging the company with willful submission of false information to CIRB. The accusation was drafted by the attorney assigned to the case, and that attorney sought the assistance of the Chief of the Rate Regulation Division for the technical aspects of the allegations. The auditor just assumed the draft had been prepared by the Chief of Legal and did not seek confirmation as to who had prepared it simply because the draft bore her name instead of the attorney's name. These events took place on a Friday. When the Chief of the Legal Division, who had been out of town that day, returned to the office on Monday, staff counsel advised her that the president of the company and its counsel would come to the Department to discuss this matter and that the meeting had been approved by the Chief Deputy who had been in touch with the insurer during the preceding week. The Chief of Legal and staff counsel did meet with these two persons and discussed the action proposed by staff counsel. The Chief of Legal was of the opinion that an accusation which would require a hearing under the Administrative Procedure Act on a very highly technical and very difficult to fully understand issue, even for attorneys of the Department with long years of experience in this business, might not be the best approach to handle this case. Since the Department's main concern was that the filings made with the CIRB included this arbitrary factor, thereby distorting data which would affect the experience modification of all of these insureds, corrective action rather than an APA hearing which would result in a suspension or a fine would be more appropriate. The auditor has placed great weight on the fact that the draft of this accusation was discussed with the company without recognizing the difference between the charges in the accusation and the only results which could have flown therefrom with the corrective actions actually taken by the insurer as a result of the stipulated order. No doubt the insurer would have been far better off paying a $10,000 penalty instead of taking the following steps.

The stipulated order, a copy of which is attached hereto, directed the company to review all of its CIRB filings since April, 1973; revise and correct every unit statistical filing; and report to the Commissioner by policy numbers and dates and by unit statistical reports which were subject to correction and finally affect premium adjustments which are made necessary by these corrections. As a result of the stipulated order, the insurer revised 1,973 filings with CIRB, causing the Bureau to issue 684 revised experience rating modifications. 336 of these involved 304 insureds still with this company who received refunds of premiums totalling some $176,000. The insureds who had taken their business to other insurers likewise received their appropriate premium refunds. In addition to the return premiums made by the company, the cost to the company of handling this corrective action was in excess of $200,000. The final action taken by the Department was far more punitive and severe than anything that could have been obtained through the issuance of an accusation, and no benefit would have flown directly to the insureds affected had the matter been handled through the routine hearing procedure.

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August 18, 1975

Mr. Wesley J. Kinder
Insurance Commissioner
1407 Market Street
San Francisco, California 94103

Attention: Angele Khachadour
Deputy

Re: Notice of Non-Compliance and Order
File No

This is a report of the action taken b
Company pursuant to the above order as revised and amended on May 30, 1975.

The procedure which was followed in reviewing and filing revised unit statistical reports to eliminate the effect of the loss development factor adjustment was discussed with and approved by Mark Gerlach and John Yates of the California Insurance Department on March 5, 1975. The procedure essentially involved six steps:

(1) preparation of a master run from computer of all claims which had at any time had a loss development factor applied to them;
(2) preparation of a worksheet for each claim on the master run;
(3) review of the original unit statistical cards filed with the California Inspection Rating Bureau covering all policies which had claims against which a loss development factor had at any time been applied;
(4) review of the individual claim file jackets showing the reserve and payment history of each claim against which a loss development factor had been applied;
(5) review of the pertinent reserve analysis forms depicting the computation of the reserves in effect at the time of the unit statistical filings; and
(6) preparation of revised unit statistical filings with the California Inspection Rating Bureau deleting the loss development factor.

Note: Company has advised that cost of taking this corrective action exceeded $200,000.

Appendix B #5

The procedure to be followed in submitting revised unit statistical reports was also discussed with the California Inspection Rating Bureau ("Bureau"). The Bureau requested:

(1) that appropriate second or third reports on any policy affected by a loss development factor be submitted at the same time as any revised first or second reports, even if the former had no loss development factor in them; and
(2) that the reports be submitted separately from normal unit statistical filings and as a group by calendar quarter.

Following the procedure approved by the California Insurance Department, reviewed all its unit statistical filings made with the Bureau on and after April 1, 1973, which had in any way been affected by the application of a loss development factor adjustment. As a result, and in accordance with the procedure requested by the Bureau, 1,973 revised unit statistical reports were filed with the Bureau in order to eliminate the effect of the loss development factor adjustment on all unit statistical filings previously made by with the Bureau and to enable the Bureau to issue appropriate revised experience rating modifications. Filings covering policies with inception dates in January, February and March were made on April 14, 1975. Thereafter, filings affecting policies incepting in the last, third and second quarters were completed on May 1, May 8 and May 23, 1975, respectively.

Following said filings, the Bureau issued 684 revised experience rating modifications. The vast majority of these (95.2%) involved changes of two percentage points or less. 336 of these revised experience rating modifications involved 304 current insureds of Industrial. Industrial has now issued appropriate premium returns to all 304 of these insureds, totaling $176,257.

We will be happy to discuss with you any further details of any of the actions taken by . I will be out of town until August 25, 1975. Please contact me if you wish to discuss any aspect of this report or the actions taken by pursuant to the above Order.

Respectfully,

Secretary and Corporate Counsel

DWS:dk
cc:John Faber

Dold Ins Hard

STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE

NOTICE OF NONCOMPLIANCE
AND ORDER; STIPULATION

File No.

To: ompany
San Francisco, California

WHEREAS, Company, San Francisco, California, has been since May 3, 1939, and now is, licensed under a Certificate of Authority issued by the Insurance Commissioner of the State of California authorizing it to transact insurance in the State of California; and

WHEREAS, during the month of November, 1974, the Insurance Commissioner conducted an investigation of that portion of the business and affairs of Company relating to workmen's compensation insurance; and

WHEREAS, said investigation revealed that during the period commencing in April, 1973, and terminating in November, 1974, Company planned, implemented, installed and administered a program entitled "Loss Development Factor Adjustment," (hereinafter referred to as LDFA), under the provisions of which, through application of a so-called LDFA factor to the then-outstanding reserve amounts on certain individual open workmen's compensation claim cases, those case reserves were thereby increased by first 21% and then by 29% constituting as of September 30, 1974, an increase in reserves on a case basis of approximately $8.5 million; that the LDFA program was implemented and administered in such a fashion

from its inception that the individually increased open claim case reserve figures were reported to the California Inspection Rating Bureau by means of the Unit Statistical Filing Reports made by the company under each such policy thereby affecting the statistical experience and the "experience modification" of certain policyholders for rate-making purposes resulting in increases in certain premium charges for workmen's compensation insurance; and

WHEREAS, certain workmen's compensation retention and group participating policies with inception dates of January, 1971 (expiration dates of January, 1972) were in process of review for dividend calculation; that the LDFA program was devised under which a percentage factor was applied to the case reserves on outstanding open claims; that in furtherance of this program each month the company's Data Processing Center identified and prepared computer lists of those policies expiring as of a given month and against which the LDFA factor was to be applied; that such lists were then furnished to the home office claims department for referral to appropriate division claim managers for application of the established LDFA factor; that said factor was applied through preparation and disposition of an "incurred advice form" which form was used to report the adjusted reserves; that said form was distributed to the Data Processing Center which in turn recorded the net reserve change on magnetic tape and reported the same to the Statistical Department of Industrial Indemnity Company for filing with the California Inspection Rating Bureau in conjunction with its Unit Statistical Filings on individual workmen's compensation policies; that thus, these Unit Statistical Filings to the Rating Bureau on individual policies did incorporate and include the LDFA increases in case

reserves; that such reporting of the individual policyholders' loss experience consequently adversely affected certain policyholders' "experience modification" for rating purposes; and

WHEREAS, the Insurance Commissioner has good cause to believe, based on the foregoing findings of fact, that Industrial Indemnity Company has filed incorrect and improper information with the California Inspection Rating Bureau in violation of the requirements of the California Workmen's Compensation Unit Statistical Plan, which has the effect of increasing premiums for workmen's compensation insurance in violation of the provisions of Article 3, Chapter 3, Part 3, Division 2 of the Insurance Code of the State of California and that grounds exist to order Industrial Indemnity Company to take corrective action pursuant to the authority vested in the Insurance Commissioner in said Article 3, Chapter 3, Part 3, Division 2 of said Insurance Code.

NOW, THEREFORE, GOOD CAUSE APPEARING, Industrial Indemnity Company is hereby Ordered to make a review of all its workmen's compensation policyholder Unit Statistical Filing Reports made to the California Inspection Rating Bureau during the period commencing April 1, 1973, and thereafter; and to revise and correct each and every filing under which any loss experience figures or reserves have in any manner been revised and increased by the application of any Loss Development Factor Adjustment; and to revise and correct such Unit Statistical Filings so as to eliminate any and all increases by application of such Loss Development Factor Adjustment; and to make available to the Insurance Commissioner by policy number and policy dates and by Unit Statistical Reporting

(i.e., first, second or third reporting) the Unit Statistical Reports which are the subject of such correction; and, after recomputation of the experience modification in light of the corrected experience figures by the California Inspection Rating Bureau, Industrial Indemnity Company shall effect appropriate premium adjustments for affected policyholders; and to file a written report on the action taken with the Insurance Commissioner by no later than May 31, 1975.

IT IS SO ORDERED this 2nd day of January, 1975.

GLEESON L. PAYNE
Insurance Commissioner

By Angele Khachadour

ANGELE KHACHADOUR
Deputy

STIPULATION

Company hereby stipulates to the foregoing Notice of Noncompliance and Order being filed and maintained as a public record of the Insurance Commissioner.

Dated: January 3, 1975

Title

Auditor General's Analysis

Case 5

The Department's explanation contends that negotiating the charges was necessary because prosecuting the matter through the hearing process could not have resulted in discipline other than a suspension or fine. This is incorrect, both because of the Department's broad authority to order a variety of punitive actions and because the licensee could offer a settlement at any point in the disciplinary procedure.

The Department also contends that the complexity of the case might have been beyond a hearing officer's comprehension, yet the Department admits that the main concern was simply that invalid reserves information was being filed with the CIRB. In our judgement, the Department has not reasonably explained the need for extraordinary negotiation of draft charges in this case.

Report 292
Appendix B

Case 6

In 1974, the Investigation Bureau received a complaint alleging misrepresentation and illegal rebates by an insurance agency. The case was closed "no violation" 21 months later on the basis of the accused's denials and a question whether the accused had been licensed by the Department at the time of the allegedly misrepresented insurance sale.

Department's Response

Case No. 6, Page B-12

The case was not closed on the basis described in the auditor's report but because it was found the subject had made no misrepresentation to the master policyholder. The complaint was from a certificate holder who received their information from the master policyholder. The terms of the policy stand. Extensive investigation developed no evidence of rebates, developed only that the rebates were administration fees paid to the master policyholder which is legal; but that they were being paid on the basis of a percentage of premium written which is not proper according to departmental interpretation. This portion of the investigation was resolved by Legal Division obtaining compliance and the subject eliminating percentage of premium as a basis for paying such administration fees.

Auditor General's Analysis

Case 6

The Department's explanation does not join the two issues raised in the case description:

(1) The 21-month delay, and (2) closing the case on the basis of the agency's denials and a question of whether the agency was properly licensed. Our description relied heavily on the case file summary prepared by the investigator on the case.

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Report 292
Appendix B

Case 7

a. In 1964, a special examination of an insurer by the Department's examiners disclosed an insurer's failure to refund premiums to insureds as appropriate. The insurer promised corrective action in 1965.

b. In 1966, a regular examination of the insurer disclosed continued failure to refund premiums. The insurer's parent company promised corrective action.

c. In 1968, the Department made another special examination as a result of persistent rates of policyholder complaints of insurer failure to return premiums. The chief deputy commissioner said that corroboration of the complaints should lead to action against the company's license. However, after the special examination corroborated the continuing problem, the staff attorney (now chief of the Legal Division) to which the case was assigned decided that only a warning letter was necessary because of the company's promises of future compliance.

Department's Response
Appendix B-12 Case #7

A limited examination of the insurer was conducted in 1968 because of the large number of complaints received from the public regarding return premiums. Two prior examinations in 1964 and 1966 had disclosed a similar problem existing during the periods covered by those reports. Pursuant to directives issued by a Chief Deputy, the matter had been assigned to a staff counsel - (once more the Auditor General calls attention to the fact that staff counsel is now the Chief of the Legal Division) for the purpose of collecting all relevant data available in the various offices of the Department and reviewing the results of the special examination and take action against the insurer's license. The report then states that the Chief of Legal decided that only a warning letter was necessary, thereby implying that failure to follow directives showed leniency to an insurance company. The file in fact reveals that in 1967 the company had failed to live up to its prior commitment to the Department that refunds of premium would be handled promptly; that a result of those initial findings, meetings were held with the company management, which had almost entirely changed during the spring of 1968. The president was new and did commit himself to a policy with regard to requests for return of premiums during the 10day free look period which was satisfactory to the Department. The file contains an explanation as to why the prior management did not meet its commitment to the Department. Based on the facts presented by the company, in mitigation for what had happened, recommendation was made to the Chief Deputy that no formal order be issued against the company at this time. No one included in the case, including the actuary who reviewed the findings of the examination, the Chief of the Legal Division, and Chief of the SA Division objected to counsel's recommendation. This recommendation was approved by the Chief Deputy and the matter closed with a warning letter in July 1968. In August of that year a report was received indicating that the company was meeting its commitment and was promptly refunding return premiums. There have been no problems with this insurer regarding this question. Here again the auditor chose to ignore the facts contained in the file and to deliberately distort the action taken by counsel in a manner designed to indicate leniency toward insurers. It is not at all clear also why a 1968 case was dug up by the auditor when allegedly he limited his review to 1974-76.

INTER-OFFICE COMMUNICATION

Please use a separate letter for each subject

TO _____ OFFICE President

FROM _____ OFFICE Management Sales Department

SUBJECT Ten-day "Free Lock" Refunds DATE August 12, 1968

For the week ending August 9, 1968, we made twenty-nine refunds; eighteen (62%) in three days or less; twenty-five (90%) in five days or less. Only one refund was made in over seven days and none over thirteen.

Of the twenty-one refund requests received in August and closed through August 8, 1968, eighteen (85%) were refunded in three days or less and all within five days. This would indicate a continuing improvement in the adjustment by the Home Office people in handling the extensive new procedure set up.

KDO:gt

Appendix B - # 7

July 19, 1968

Dear Mr.

As you were advised during our last telephone conversation, a copy of your letter of July 10 was forwarded to our Los Angeles office for review by Mr. , Chief Deputy Insurance Commissioner.

I have just been advised that in light of the commitments made in your said letter, no formal disciplinary action will be instigated against your company at this time.

I was personally very pleased to see that you made the decision to refund the premium to any insured who requested cancellation of a policy within the 10-day free look period without attempting to conserve the business prior to making such refund. The desirability of conserving the business should indeed be left to the agent and the insured should not be penalized by the agent's negligence in failing to contact the insured immediately. I am quite confident that this new procedure will considerably reduce the number of complaints received by our Policy Services Bureau against your company.

You should be advised, however, that if in the future evidence comes to our attention indicating that you have failed to meet the commitments set forth in your letter it will very likely result in our undertaking formal disciplinary action. I trust that we will have no reason to regret our decision to forego taking such action at this time.

Thank you for your cooperation.

Very truly yours,

RICHARD S. L. RODDIS
Insurance Commissioner

by
ANGELE KHACHADOUR
Counsel

AK/dra

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State of California

Memorandum

To : MISS ANGELE KHACHADOUR Date: July 19, 1968

From : **Department of Insurance**
107 South Broadway, Los Angeles 90012

Subject: [redacted] Life Insurance Company SF-10238-E

I will follow your recommendation. I suggest that you wrap the matter up at this point by confirming by letter that you have received their statement that they will not attempt to conserve the business before returning the money and it is the Department's position that it would be unacceptable for them to do so.

HARRY O. MILLER

HOM:ly
cc: Mr. Edward J. Germann
Mr. Henry Wikstrom

Mr. Harry O. Miller
Chief Deputy Commissioner
Los Angeles Office

July 12, 1968

-- Angele Khachadour

INSURANCE COMPANY

On July 9, Mr. Jacks and I met with Mr. R. C. , President of subject company to discuss the findings of our special examination regarding delay of refunds made pursuant to the "lo-day free look provision". It was Mr. Bagley's contention that since he became president of the company this problem has been to a great extent already resolved. He is quite willing to have us send a new examiner to check the last few months in order to confirm the alleged improvements. We advised Mr. of our position on this matter particularly with regard to the issuance of a 1065 order. Attached is a copy of his written response.

I am inclined at this time to reserve my earlier position and to recommend that no formal order be issued. Mr. Jacks has indicated that he would concur with this recommendation. Please advise as to whether you will insist on a formal order. I shall refrain from responding to Mr. Bagley's letter until receipt of your directives.

ANGELE KHACHADOUR

AK/dra

cc: Messrs. E. J. Germann
Henry E. Wikstrom
Eugene Jacks

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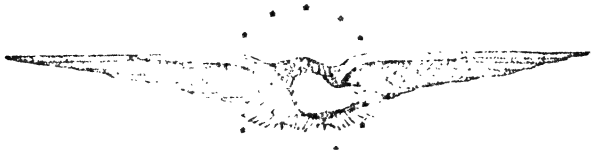
A LEGAL RESERVE CAPITAL STOCK COMPANY



Miss Angele Khachadour
Counsel
Department of Insurance
State of California
1407 Market Street
San Francisco, California 94103

Dear Madam:

Per your request, following our discussion yesterday, I am pleased to advise that I believe the paramount problem that we discussed should be resolved to the Department's satisfaction and the company's once and for all.

I considered, with my Department Heads, many various ways of handling the problem and with the exception of the one outlined below, found them all too time consuming for one reason or another.

Henceforth, whenever we receive a request for a refund from a policyholder indicating dissatisfaction with the policy, and this request was initiated within the 10 day free-look period, we will immediately refund the amount shown on the application. The only correspondence with the policyholder will be an acknowledgment of the fact that we have received this request and inclosed will be our check for full refund. A copy of this correspondence will be sent to the agent and if he wants to try to conserve the business it will be up to him to determine what initiated this letter of dissatisfaction and to obtain from the policyholder a new check or the original refund check with a signed statement indicating that she or he is satisfied with the policy and wants to keep it.

We are hopeful that with this system policyholders will receive our refund checks, in all cases, well before the 15 days that we discussed and on an average of 3 days.

In analyzing the special report of examination of the
Insurance Company, as of May 6, 1968, I sincerely hope that any judgment you may make that you will take into consideration the fact that I have been President of this company for 5 months; that I have been in the

insurance business in California for approximately 18 years; and that it is a personal goal of mine to conduct both my company business and private affairs with maximum integrity. Where the company has been inefficient, I will do my utmost to resolve the problems that caused this inefficiency so that we as a company can have an enviable record. I realize that our former President made commitments that due to many factors were not entirely lived up to. I feel that you will agree with me that this was not deliberate. I would be very happy, if you thought it necessary, to supply you with his medical records. Suffice to say that he was a very sick man with many ailments, the most serious being a heart attack that occurred around December 1964 with many complications. After several hospital confinements, he was admitted to Mt. Zion Hospital for a mammary implant to the left ventricle - the Vineberg procedure. He did not respond as expected, or as hoped, so it was finally necessary to retire him. During this period of invalidism, a Department Head who had been with us approximately 12 years and who was directly responsible for this department and responsible only to the President, did not fulfill her duties as expected. I was forced to terminate her shortly after I became President in order to improve the efficiency of this department.

As I stated in my conversation with you, there has been a marked improvement in the handling of refunds but in order to avoid any continuation of the problem, I have adopted the above method. If this does not meet with your complete satisfaction, or there are any refinements that you feel may be of further benefit to the company or to its policyholders, please advise.

Sincerely yours,

President

RCB:br

Mr. Eugene Jacks May 10, 1968

-- Angele Khachadour

COMPANY
Progress Report of the Current Special Examination

Examiner Thiemann and I met yesterday to review his initial findings. It appears that the Company maintains a register of all refunds made to the insureds. These refunds for the most part are made following requests by the insured of cancellation of his policy. Some are also made as a result of the Company electing to recind the contract of insurance.

During 1967 the Company issued 17,798 policies and made refunds on 1,005 policies. Our examiner has been instructed to review a scientific sampling of the 1,005 refunds. The method used will be a review of every sixth refund or a total of about 160 files.

In accordance with my instructions Mr. Thiemann initially reviewed a number of refunds made during the month of January 1967. His summary of the files reviewed clearly indicate that the Company is negligent in not making prompt refunds. It is obvious that the Company has failed to live up to the committments its president made in December 1965 to Mr. Swindell regarding this very same problem.

I expect Mr. Thiemann's examination to be completed by the end of this month. I shall, of course, keep you informed of any new developments.

ANGELE KHACHADOUR

AK/dra

cc: Mr. Miller
Mr. Germann
Mr. Wikstrom

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State of California

Memorandum

To : MR. CHRISTY P. ARMSTRONG
MR. EDWARD J. GERMANN
MR. HENRY E. WIKSTROM

Date: April 3, 1968

From : Department of Insurance
107 South Broadway, Los Angeles 90012 - Chief Deputy Harry O. Miller

Subject: Insurance Company

I am sending each of you a copy of the file on this case. Mr. Wikstrom should assign an attorney to oversee the collection of evidence. If the field examination corroborates the information that we already have, the attorney should be the same one who will draw the pleadings for a proceeding against the Certificate of Authority of this company, based on Sections 701 and 704 (a) and (b).

Before the examination actually begins, PSB should prepare an individual summary of each of the cases regarding return premiums that it presently has, using Mr. DeSpain's summaries as guides as to format.

The attorney should carefully brief the examiners on what they are to look for, what evidence they are to collect, and in what form they are to collect this evidence, and instruct them that they are not to discuss the reasons for this special examination with anyone other than the people directly involved in the Department in this investigation, and are not to mix socially with the employees or officers of the Westland Life Insurance Company during the special examination.

The examination should follow Mr. Germann's recommendation made in the second paragraph, page three of his February 9 memo to me.

Before the examination starts, both the lawyer handling the investigation and any disciplinary action, and the examiners are to discuss the field examination program for this examination of this carrier with C.I.A.D. and get C.I.A.D.'s approval of the proposed program. The attorney and the examiners handling the examination are to report to the person designated by Mr. Germann to coordinate this activity, and the overall strategy for the collection of information by this special examination will be in C.I.A.D. Mr. Germann should assign either himself, Mr. Cook or Mr. Jacks to be responsible for this.

HARRY O. MILLER
Attach
cc: Mr. J. D. Thomas

Auditor General's Analysis

Case 7

The Department does not challenge the factual merits of our description of this case, and the Department's explanation only corroborates the extraordinary delay in securing corrective action by the insurer.

The Department also expresses concern about our selection of this case for review. Our review was generally limited to licensees whose disciplinary files were active in 1974-76, although we also investigated some older cases brought to our attention. Thorough review of recent cases often requires researching the licensee's disciplinary history--records of which are accumulated in each case file.

Case 8. Background: The Insurance Code authorizes the Department to suspend an insurer's privilege to appoint temporary agents if less than one-third of the appointees pass the Department's license examination in a given year. The Code requires the companies to submit by August 15 of the following year their annual reports of such rates of exam passage.

Case History:

a. In 1969, only 20 percent of a life insurer's appointed temporary agents passed the exam. In January 1971, the Legal Division initiated action against the insurer's appointment privilege. In June 1971, the Legal Division suspended the insurer's privilege for 60 days. The Legal Division said it was lenient because it had taken so long to act and because the insurer promised to improve the training of its agents.

b. In 1973, only 14 percent of this insurer's appointees passed the exam. In October 1974, the Legal Division formally offered the company a 365 day suspension of appointment privileges. The insurer signed the offer, but substituted 180 days as the suspension period. In January 1975, the chief of the Legal Division signed an order specifying the reduced penalty. There is no evidence in the case file of any rationale for the penalty reduction.

c. In 1974, only 16 percent of the company's appointees passed the license exam. In September 1975, the Legal Division suspended the company's appointment privilege for another 180 days.

d. In December 1975, the Investigation Bureau disclosed that the company had allowed unlicensed agents to sell insurance in violation of promises made to the Department in 1973 and the suspension of appointment privileges in 1975. The Investigation Bureau closed the case prematurely upon advice from the Legal Division that no action would be taken against the insurer even if proof of violations were found. The reason given was that the company had come into compliance.

Department's Response
Appendix B-13 Case #8

Paragraphs a, b, and c relate the actions taken by the Department to suspend the company's right to appoint agents under certificates of convenience pending examination. In the years reported in the audit, this insurer failed to meet requirement established by law. The actions taken in 1971 related to the 1969 calendar year performance and was the first time the law had been in effect and was being enforced. The periods of suspension for this insurer was consistent with other insurers and were of relatively short duration since this was the first year enforcement. This type of action is taken once a year after the results of the prior year are compiled. The normal procedure is for one attorney to be assigned to handle all of the cases for that year.

In 1974 the action taken for violations for the calendar year 1973 a counsel was assigned to the project and he developed a chart which generally attempted to provide various penalty periods based on number of certificates used and percentage of failure. It is difficult for an attorney to fit in a project involving action against 25 to 35 insurers at one time with his normal work load. Consequently, effort is made to streamline the procedures as much as possible and to avoid anything that would further delay the settlement of these cases. The attorney is encouraged to avoid taking these matters to hearing since they are both expensive and time-consuming. During this year, counsel followed the general

rule that rather than take the matter to hearing, the Department would settle if the insurer would consent to an order which would be at least twice the period of suspension of any prior suspension ordered by the Department. This was done in this case and in fact this insurer agreed to an 180-day suspension. The purpose of specifically mentioning that the Chief of Legal signed the order reducing the penalty is unclear since the Chief of Legal signs all disciplinary orders with very rare exceptions. The procedures followed by counsel handling this assignment and the manner in which most of the penalties that year were reduced could not be found in the file in that in an effort to streamline the handling of all these cases and try to control the amount of time spent thereon, counsel maintained in his office memos, analyses, and other working papers in a separate file. This is a practice we have followed every year since the enactment of the statute in an effort to avoid building up bulky files when all of the relevant data is applicable to all companies subjected to the penalty. It appears that the auditor did not review those working papers for any of the years where the Department took action for violation of this law and did not discuss this matter with counsel.

The Department was experiencing considerable difficulties in its License Division operations when it was ordered to convert its manual system to EDP. One of the more serious problems experienced during that time was the slowdown of our examination schedules, which

considerably worsened the performance of those insurers using certificates of convenience. Staff counsel made tentative recommendations for penalties ranging from 30 days to 365 days. The working file for the 1974 calendar year actions indicates that in response to that recommendation the Chief of Legal advised the counsel that since our Department had contributed considerably to the rise in the number of applicants who fail to take the exams as the exams were not being scheduled promptly enough, the maximum period of suspension which we should propose should not exceed six months and should apply primarily to those insurers who had failed the test in the prior year. Consequently, the notices sent out by counsel indicated various penalties being offered, the most severe being six months (see Exhibit B-5).

d. The auditor reports that the Investigation Bureau prematurely closed a case against this insurer for using unlicensed agents because of advice from Legal Division that no action would be taken even if proof of violations were to be found since the company had come into compliance. The investigation file indicates a handwritten note by the investigator to the effect that counsel from Legal had given such advice. That counsel has no independent recollection at this time as to whether he actually used the words written down by the investigator. A staff counsel has no authority to direct the Investigation Bureau to either investigate or to stop investigating a particular matter. The issue involved was whether this

company was violating the law by appointing agents which had received certificates of convenience through another insurer, thereby in effect riding on the coattails of another insurer. Counsel had thought that the insurer could not make use of agents licensed under such certificates of convenience through another insurer. That preliminary opinion of counsel was totally in error. The law does not prohibit a company from appointing such agents. The facts as alleged by the investigator, even if true, were not in violation of law.

Auditor General's Analysis

Case 8

The Department's explanation does not challenge the facts described in the Appendix B description. However, some of the Department's rationale conflicts with the facts. In case 8 (b), the Department explains the penalty reduction as consistent with policy instructions from the chief counsel. Yet in three other cases in the same year the supposed policy was not followed by either the staff attorney or the chief counsel. The actual procedures followed by the staff attorney were outlined in a memorandum (attached, p. 76) included in the master case file which we reviewed, contrary to the Department's assertion in the hearing. The staff attorney's memo does not refer to the policies explained in the Department's written response to this case.

The Department rationalizes its action in case 8 (d) on the grounds that the investigator erroneously closed the investigation on the basis of an erroneous legal judgment by a staff attorney. If this is the case, we recommend that the Department clarify its instructions to staff on the procedure to be followed to avoid such compound errors.

Angele Khachadour April 15, 1975

-- Philip R. Hinderberger

Certificate of Convenience Disqualification
Action for the Calendar Year 1973, SF 10976 B

Pursuant to your instructions of September 30, 1974, action was taken against Life and Disability Insurance companies failing to qualify the required number of certificate of convenience holders in accordance with California Insurance Code Section 1692.1. See Enclosure 1 for companies and type of action.

WARNING LETTERS

On October 23, 1974, the undersigned dispatched a standard warning letter to designated companies. The standard letter required the recipient to respond by January 1, 1975 setting forth the reasons the recipient failed to comply with Section 1692.1 and to specify a program designed to bring this recipient into compliance with said section. All companies receiving a warning letter responded with an acceptable program.

Accusations

A standard Accusation, Special Notice of Defense, and Order, was dispatched to designated companies. Of the 21 companies receiving an Accusation, 16 entered a Special Notice of Defense prior to the commencement of public hearings, and 5 companies failed to submit Special Notices of Defense and elected to present their case at the public hearings held on January 23, and January 24, 1975.

Findings and Conclusions

1. The majority of companies that failed to qualify the requisite number of certificate of convenience holders indicated that (1) a lack of firm management control over the process of recruiting agents (2) the difficulty of selling the

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companies' products and (3) the lack of any compensation other than commissions caused a substantial number of their new temporary agents to quit the business within a relatively short period of time. For example, Pennsylvania Life Insurance Company in an internal memoranda dated approximately April 27, 1974, reported the results of a survey conducted by the production division which indicated that Pennsylvania Life Insurance Company will qualify no more than 8% of its applicants for certificate of convenience assuming that Pennsylvania Life Insurance Company continued its current recruiting and agent retention programs and the Department of Insurance continued its policy of scheduling the examination for temporary licenses four months after date of filing. The representatives from International Order of Foresters, indicated that it loses at least 50% of its temporary licensees within the first week and even if the Department scheduled an examination seven days after each applicant filed for a temporary license, International Order of Foresters would still be required to obtain a pass percentage of approximately 83 1/3% of the remaining 50% in order to qualify under Section 1692.1.

2. During our earlier discussions of the certificate of convenience disqualification action, it was noted that the companies would probably be able to show that the Department had, in 1973, substantially prejudiced the companies by failing to issue certificates of convenience in a timely manner thereby causing many applicants to leave in despair and frustration. During the course of negotiations and hearings not one single documentary case of prejudice caused by the Department's delay was offered. In addition, it became apparent that the primary cause of low agent retention rates was the companies' insistence that the temporary agent work without compensation until the temporary license was issued.

3. Section 1692.1 was amended effective January 1, 1974. As amended the section indicates that the privilege shall be automatically suspended at any time it is shown that the insurer has failed to qualify 33 1/3%. Although the language of the statute does not indicate any particular point in time when the privilege is automatically suspended, it appears that the earliest date remains July 1, because the insurer has six months to qualify the last person certified in a calendar year which theoretically is December 31. Also, it should be noted

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that the new section requires the insurer to report on or before August 15 on the prior year's performance. This would seem to indicate that the initial burden of record keeping is on the insurer but it does not ipso facto remove the Department's duty to maintain records. In fact, if the section is to be enforced it will be necessary for License Division to compile a report as has in the past. Under the amended section no acqusations will be necessary to suspend but a hearing must be held if the suspension is to be annulled or confirmed and some form of notice must be sent to each affected insurer.

4. Under the section as amended, the words "for any reason" have been deleted. In the past, the Department has held the position that once an insurer has certified a person and the certificate of convenience is actually issued, then that person shall count for purposes of the computation under Section 1692.1 regardless of the reason for non-qualification. Death, insanity, incarceration, defalcation of the agent by another insurer, fired or quit, they all count against the insurer. The Department has taken this position because of the legislative history of the section which indicates the pass percentage was set at 33 1/3% after the industry had hammered down the figure using the argument that all of these cases should be anticipated before the pass percentage was fixed. This makes the section easy to enforce because there are not facts or questions in issue other than issuance of the certificate of convenience and failure to qualify within the required period of time. It is my opinion that the deletion of the language "for any reason" does not change the method of computation because to change the method of computation is tantamount to a change in the acceptable pass percentage.

5. During the proceedings for calendar year 1973, the only mitigation that had any affect on the Hearing Officer was proof of improved performance. Many plans to institute internal controls and to recruit high quality individuals fell on deaf ears. The question may arise, how can an insurer who has had its privilege suspended have any performance in which to show mitigation. An insurer still may seek to have its agents qualify for permanent licenses without the certificate of convenience and the performance under these conditions could be

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used to show that the insurer has instituted internal controls or taken whatever steps are necessary to qualify its agents. Thus in subsequent years it is recommended that improved performance be the primary criterion when assessing suspensions.

6. During the proceedings for calendar year 1973, no stipulated settlement included a period of suspension less than double any prior period of suspension. No insurer resisted this approach. In addition, every insurer was required to file with the Department a detailed plan for recruiting, screening and training its certificate of convenience holders. These plans if submitted at all were usually poorly drafted and contained nothing but euphemisms. In subsequent years it is suggested that plans be submitted and approved as a condition precedent to any discussion concerning the termination of the automatic period of suspension.

7. Mr. Hubert has indicated that the life and disability insurers who do not use the certificate of convenience procedure currently qualify approximately 80% of all persons appointed. This should be compared with the dismal 10% pass ratio of the major individual disability insurers who rely heavily on the certificate of convenience procedure to procure temporary agents.

8. During the proceedings for calendar year 1973, it was determined that one insurer had failed to comply with the training records keeping requirement of Section 1690. Action was taken against this insurer and approval of the in-house training program was withdrawn. It is suggested that a net of interrogatories be sent to each insurer to determine whether or not they also have failed to maintain records and if there is any indication that a company is not in compliance, a formal investigation should be commenced and appropriate disciplinary action taken.

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Case 9. In 1969, only 30 percent of another company's appointees passed the license exam. In January 1971, the Legal Division formally offered a 30 day suspension penalty. The company did not return the signed offer until July 1971, despite written instructions on such offers that they expire after 15 days, whereupon the Department takes the matter to public hearing. In July, the Legal Division accepted the signed offer and the period of appointment suspension was ordered to begin in August.

Department's Response

Appendix B-14 Case #9

This insurer's right to obtain certificates of convenience pending examination was suspended for calendar year 1969 for a period of 30 days as only 30.8% of its applicants licensed succeeded in the exam. As was mentioned for case #8, it was the first year the law had been in effect; and all suspensions were of short duration and fully consistent with one another. The pleadings were mailed in January 1971, with a letter requesting an explanation as to what the insurer was doing about this problem. The letter indicated that if the response was satisfactory the Department might propose entering into stipulations sometime in May. The offer of the stipulation for a 30-day suspension was made in June 1971, and the comapny was given 15 days to respond. The company did. The prior explanation provided by the company as to what had happened was satisfactory, and the action was completed in July. We are at a loss to understand why this case deserved to be listed in this appendix as an example of improper conduct by Depertment staff. The auditor is incorrect in claiming that the attorney offered a 30-day suspension in January. That is not correct. In January only the accusations were sent. The offer of a 30-day suspension was not made until a response was received to the April follow-up letter. It is difficult to see why the attorney's action to follow-up on those who had not originally responded was so grossly improper as to justify inclusion of that case in the auditor's report.

Auditor General's Response

Case 9

The Department contends that the penalty offer was not sent out with the accusation, as is normal procedure, but was delayed six months. If the Department could document this chronology, we would correct Appendix B.

Case 10. An examiners' report in December 1974 indicated that another insurer received numerous complaints against its agents for misrepresenting policies to insureds. Subsequent analyses by the Surveillance and Analysis Division and the Policy Services Bureau indicated that the insurer's procedures appeared to be the source of the problem. In May 1976, a Surveillance and Analysis Division analyst, and in October 1976 the Division's legal counsel recommended to the division chief that legal action be taken against the insurer. There is no record of the chief referring the case for further action.

Simultaneously, the Investigation Bureau's investigation of the insurer's agents revealed proof of systematic illegal procedures of the insurer. However, in February 1977 the chief investigator decided no legal action was warranted because a case had not been developed against a specific agent.

Department's Response

Case No. 10, Page B-15 (Middle Paragraph)

The Investigation Bureau's inquiry did not reveal proof of systematic illegal procedures by the insurer. The issue involved Insurance Code Section 10276 which provides that a policyholder may return the policy of disability insurance within 10 days of delivery and have the full premium paid refunded if not satisfied for any reason. It states further that the policy shall be void from the beginning and the party shall be in the same position as if no policy or contract had been issued. There is nothing in this section to prevent the insurer from inquiring of the insured as to the reason for dissatisfaction and to attempt to resell or "save" the business. One investigator is of the opinion that the phrase "shall be void from the beginning" prohibits such conduct and reported it to the auditor who apparently accepted this relatively inexperienced person's judgement without further inquiring with the investigator's supervisors or with Department's attorneys who provide interpretations of the sections for investigator's use. The investigator has been informed that the Department's position is that a policy is a contract between two parties and a mutual agreement may be reached to reinstate from the same application and with the same policy number and form. Requiring that a new application be taken and a new policy issued is not of practical benefit. The case was not closed because a case had not been developed against a specific agent, but because the insurer advised the investigator by letter that in early 1976, they began to realize their procedure in turning over responsibility for making such refunds to agents was causing unwarranted delay in the insureds receiving their refunds. They changed their internal procedure to insure that a refund would be sent no longer than 20 days after receipt of request. The matters the investigator had been working on occurred in 1973 and 1974. The instructions were, if a problem still existed, to document a pattern and prepare a case on the insurer to refer to the Compliance Bureau.

EDWARD L. MIDDELTON
Chief Investigator

Auditor General's Analysis

Case 10

The Department apparently did not submit an explanation for the first paragraph of the case description in Appendix B.

The Department's chief investigator offers a legal analysis of the relevant Code section to rationalize his handling of the aspects of the case investigated by his staff. Contrary to the chief's assertions, the investigator assigned to the case has more law school background than most investigators, including the chief. The investigator's legal analysis is therefore not inherently less credible.

In further contradiction of the record, the chief suggests that the investigator's analysis was not accepted by any of his superiors. In fact, the appropriate supervising investigator approved the investigator's analysis and recommended the case be referred to the Legal Division. (see attached memo p. 85)

The chief investigator's contentions regarding the closing of the case also contradict the facts on file. In a handwritten note to the investigator on the case, the supervising investigator noted: "He (the chief investigator) said we have to build a specific case . . . (illegible) . . . prior to submitting to CB (legal division)." (See attached copy p. 86)

"Route Slip" attached to case analysis prepared by investigator.

ROUTE [illegible]
STATE OF CALI[illegible]
STD. FORM 110 [illegible]

TO:
Ed
ED MIDDLETON, chief investigator

FROM
Bob
Bob Donnachie, SF supervising investigator

PHONE

FOR ACTION AS INDICATED

☐ REPLY—MY SIGNATURE	☐ SIGNATURE	☐ NOTE AND FORWARD
☐ REPLY—COPY TO ME	☐ APPROVAL	☐ NOTE AND FILE
☐ PLEASE SUMMARIZE	☐ ACTION	☐ NOTE AND RETURN
☐ PLEASE INVESTIGATE	☐ COMMENTS	☐ PLEASE PHONE ME
☐ FORWARDED PER REQUEST	☐ INFORMATION	☐ PLEASE SEE ME

REMARKS: I think legal should put the co on notice re this matter, we have handled many complaints concerning this.

SF12246-A

Ed Middlehan, chief investigator

12-7-76

Bob Dannaclio, SF supervisor

2-10-77

Report 292
Appendix B
Case 11.

In 1969, the examiners reported that the directors of a life insurer had conflicts of interest with their sales representatives, in violation of Insurance Code Section 10434. Rather than revoke the insurer's license as required by Section 10435 of the Code, the Legal Division permitted the insurer to have the directors resign.

In a memo to the commissioner from the chief of the Legal Division, the Department's reasoning became clear for not following the Code's mandate in such cases. She was concerned that Section 10435 was unnecessarily punitive, and that it was unfair since it only applied to life insurers, while other insurers could have such conflicts of interest without reproach. However, the Department's legislative representative told us the Department has taken no action to seek amendment of Section 10435.

In her memo on the subject, the chief of the Legal Division stated that in the particular case noted, "I will concede that corrective action was overdue but I do not understand why we proceeded with such alacrity against (this insurer) while allowing many other carriers to violate the provisions of this section."

Appendix B - 15 Case #11

An examination report as of 1969 dated August 1971 revealed that a number of directors and officers of the company were licensed as agents and received commissions on business placed with the company. The very purpose of organizing this company was to enable automobile dealers to place their credit life and disability insurance coverage with a company in which they had a financial interest. Such an arrangement wherein directors and officers of a life insurance company receive commissions on business they place with a company is prohibited by law because of the conflict of interest such relationship generates in that it is presumed that an officer or director could abuse his position in the company by placing poor business with the company which no other insurer might be willing to accept. The law provides that where such a situation exists the Commissioner shall revoke the certificate of authority of the insurer. The Department staff has always been very troubled by the harshness of this statute, which is unique to California, especially where there is no showing of any harm to the company or its policyholders. Credit life and disability insurance is governed by extensive regulations in California, and the Insurance Commissioner sets the rates. The directors and officers involved in this case were also stockholders of the company. Since no harm whatever had come to the public by this arrangement, to revoke the C/A of the company and to force the stockholders to organize a new company, would simply have generated expenses inuring to the benefit of of an attorney but would not have served any valid or proper regulatory purpose. Therefore, the staff, instead, recommended that the officers and directors who placed business with the insurer resign from their positions and that a new board whose members had no financial interest in the company be elected to run the business of the company. Everyone in the Department was in full agreement with this proposed settlement and the eight directors out of a board of 14 resigned at the next stockholders meeting and the board was thereby brought into compliance.

Mr. Lawrence C. Baker, Jr. November 8, 1971

-- Angele Khachadour

Insurance Company -
Insurance Code Sections 10434 and 10435

I met with Mr. , President of subject Company, on Wednesday, November 3, at which time he delivered a memorandum setting forth the position and stock ownership held by each of the members of the Company's board of directors. Attached is a copy of said memorandum.

Having been previously apprised of the prohibition stated in Insurance Code Section 10434 and the consequences of violations of said section stated in Section 10435, Mr. readily admitted that he had been able to resolve his problem only in part. He requested additional time to bring his board of directors into full compliance with said requirements. I advised Mr. that I would review the material and information submitted and would forward same to you with my recommendations. The following is my assessment of the data submitted and my recommendation for further action in this matter.

(1) Director is chairman of the board of , National Bank and a very minor (I believe substantially less than 10 percent) stockholder of said Bank. All the Bank's credit insurance is written through subject Company with an expense allowance of 5 percent and, it is believed, an experience rating refund of about 40 percent. The 5 percent represents reimbursement for expenses incurred in the handling of the insurance. The experience rating refund, however, would fall squarely under the first paragraph of Section 10434 since it is in the nature of compensation to the Bank for the writing of said business. As such, therefore, said compensation insures directly to the benefit of said director, either as chairman of the Bank's board or as stockholder of said Bank.

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(2) Director has a controlling interest in an automobile dealership writing all its business through subject Company. The son of Director is a licensed agent and owner of an insurance agency which receives all commissions payable on the business generated through the dealership. The son is an adult and maintains a separate household from his father. The fact before us at this time is that allegedly no part of the compensation paid on the business goes to Director . If this is correct, I am of the opinion that Director would not be in violation of the law.

(3) Directors are not in violation as they have no connection with any organization writing credit insurance through subject Company.

(4) Director has a controlling interest in an automobile dealership which received all commissions paid by subject Company on the credit insurance generated by said dealership. Director is in violation and will, of course, have to resign from the board.

(5) Director is a director and minor stockholder of the a National Bank and in the identical position as Director.

(6) Director is sole owner of an automobile dealership and also serves on the board of directors of the National Bank. Both the dealership and the Bank place their credit insurance with subject Company. The insurance agency writing the credit business for the dealership has been turned over to an adult son of Director . However, Director remains in violation of subject section since he indirectly receives compensation from Commercial and National Bank, either as director or stockholder.

(7) Director is owner of an automobile dealership writing its credit business through subject Company. He has turned over the insurance agency to his adult son and is in the same position as Director Here again, if the facts are correct, he is not in violation of the law.

(8) Director owns an automobile dealership writing its credit business through subject Company. Director is clearly in violation and will have to resign.

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(9) Director is in the same position as Director and will have to resign.

(10) Director is President and Managing Officer of an automobile dealership which places its credit business with subject Company. The commissions on said business are paid to the Three T's Corporation. Director has no financial interest in said corporation and therefore does not stand to benefit in any way, either directly or indirectly, from the business placed by the dealership with subject Company. It is believed that he is in compliance with the Law.

(11) Director owns an automobile dealership which places all its credit business with subject Company. Director is in violation and will have to resign.

Based strictly on the information submitted and without any independent investigation of its accuracy, it has been determined that, of the 14 directors on the board, eight are in violation of Section 10434. Although Mr. fully realizes that those in violation will have to resign from the board of directors, he is concerned about the problems a sudden change in the makeup of the board may cause at this time since his Company is in the process of selling additional stock. He would appreciate being given until the next general meeting of the stockholders, which is scheduled for April, 1972, to bring his board into full compliance with the law. In effect, he is asking us to allow these directors to serve the remainder of their terms. This will give the Company an opportunity to find replacements and will not jeopardize the chances of the Company to sell additional stock. I did not express an opinion on the request for an extension of time to comply and simply indicated that I would submit same to the Commissioner and to you for consideration. I did, however, advise Mr. that Section 10435 mandated the Commissioner to take action.

I do not see any great harm in acceding to the request. I would, however, recommend that a formal Order be issued, giving the Company a specific date by which to comply with Section 10434. The issuance of an Accusation and the scheduling of the matter for hearings will take several months so why not give the Company the time it has asked for and obtain a stipulated Order that it will comply by a given date. Perhaps my lack of enthusiasm for immediate disciplinary action is partly dictated by the fact that we ourselves were somewhat negligent in allowing the matter to deteriorate this far. Our own dereliction should not, of course, estop us from taking the proper and necessary corrective action at this time. I am simply suggesting that in the absence of actual harm to the stockholders and policyholders a stipulated Order will

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accomplish the results desired.

Please advise.

ANGELE KHACHADOUR

AK:hcr

cc: Commissioner Barger
Mr. E. J. Germann

(Retype from original document; original unsuitable for reproduction)

-- Angele Khachadour

Insurance Company -
Insurance Code Sections 10434 and 10435

As you already know, Mr. , President of , came into our Los Angeles Office on Friday, November 19, and hand-delivered copies of seven resignations from directors of his Company, thereby bringing the Company into compliance with the requirements of Section 10434.

At that time Mr. , requested consideration by our Department of the de minimis interest three of the seven directors have in the compensations earned indirectly by them from the credit life and disability insurance business they had "placed" with life. These three directors are officers and very small stockholders of banks which write all their credit insurance business with Directors Life. Mr. has since advised me that, were the entire experience rating refunds paid to said banks to be distributed to its stockholders, said three directors would earn approximately $750, $600, and $65 each respectively.

Recognizing that Section 10434 states a fist prohibition, I advised Mr. that the matter would be submitted to you for consideration. You may recall our discussing it very briefly on Tuesday, the 23rd, but you did not at that time express an opinion as to whether you would allow any latitude with regard to our application of this section. As you know, Messrs. Baker and Germann feel quite strongly that Sections 10434 and 10435 do not give you any direction and that, in addition, disciplinary action should be taken against those former directors of this Company who are licensed as insurance producers. I have been lukewarm toward that proposition--First, because I think it is unduly punitive and, second, because I do not believe that, now that these men have resigned from the board of directors, any hearing officer would recommend revocation of their agents' licenses.

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I am very concerned about our whole approach to violations of Section 10434 and quite honestly do not understand all the excitement generated by the case. I will concede that corrective action was overdue, but I do not understand why we proceeded with such alacrity against while allowing many other carriers to violate the provisions of this section. I do think that now that we have taken action against we will have no choice but to proceed with equal speed against the other domestic as well as foreign (Section 10434(c)) life companies who are in the same position. Incidentally, this same prohibition does not exist with regard to fire and casualty companies, and many of them have officers and directors who are among their top producers.

The first one which came to my attention--through the good offices of of course-- is , an carrier with executive offices in Los Angeles and a sizeable credit life and disability writer in this State, which has on its board of directors several individuals who earn between $50,000 and $100,000 each from the credit insurance business generated from their insurance agencies in California. (See attached)

The simplest way to determine whether violations of Section 10434 exist, at least insofar as the domestic carriers are concerned, is to check the proxy statements which they file each year. These statements are filed with CLAD, and I believe they are maintained in the Los Angeles Office. Those statements will show which of the directors own an interest in organizations which receive compensation by way of commissions or otherwise from the insurer and the amount of such compensation received. In the meantime, I will correspond with Life to determine whether any of its directors is in violation of Section 10434. I trust Mr. Germann will be directed to review his proxy filings and submit to the Legal Division a report on whatever violations are indicated therein to enable us to take appropriate action.

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Incidentally, when I handled proxy filings, they came in in duplicate, thereby enabling us to maintain a second set in Los Angeles. I understand they have all been moved to Los Angeles. Would it be possible to ship north the second set to enable our Division to have access to the information contained therein? Same request is extended with respect to the insider trading filings.

ANGELE KHACHADOUR

AK:bk

cc: Mr. Lawrence C. Baker, Jr.
Mr. E. J. Germann

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January 3, 1972

90010

Re: Insurance Code Section 10434

Dear Mr.

I apologize for the delay in confirming oral advice given to you several weeks ago regarding the application of Insurance Code Section 10434 to certain directors of your Company.

You will no doubt recall having requested consideration by Commissioner Barger of the de minimis interest three of your Company's directors had in banks which place their credit life and disability coverage with your Company.

I had orally advised you that Commissioner Barger had reached the decision that said Code Section did not give him any discretion and that, no matter how small the stock holding of the director might be, the conflict of interest rule would have to be applied. I concur with the Commissioner's opinion that Section 10434 states a flat prohibition and does not allow him any discretion in its application.

Very truly yours,

RICHARD D. BARGER
Insurance Commissioner

By

ANGELE KHACHADOUR, Chief
Legal Division

AK:hcr

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Auditor General's Analysis

Case 11

At the hearing on Report 292, the Department conceded that it should recommend legislative change if it believes that I.C. Section 10435 is unnecessarily punitive. However, the Department has yet to address the chief counsel's written memo, which asked why the Department proceeded vigorously in one case while permitting other insurers to violate the law.

Report 292
Appendix B
Case 12. In June 1968, the Department made a special examination of an insurer to investigate a pattern of complaints received by the Policy Service Bureau. The special examination verified the insurer's practice of unfair treatment of policyholders, which resulted in unnecessary delay and unreasonable refusal to pay insurance claims. In September 1968, the Legal Division sent a formal accusation to the accused but the Department delayed holding a hearing to "listen to the plaints" of the insurer. No action was taken. A subsequent examination of the insurer in 1969 produced no mitigating evidence. No action was taken. Finally, in April 1975, the Legal Division closed the case because of its age.

Department's Response

None received by Auditor General.

Auditor General's Analysis

Case 12

Apparently, the Department did not submit an explanation for this case.

Enclosure 3

June 13, 1977

The Honorable
The State Senate
State Capital
Sacramento, CA 95814

Dear Sir:

I am writing you, as I feel you have the need to know about the effects of incompetent decisions and regulations made by the Department of Insurance, more specifically Ms. Angele Khachadour, Deputy Commissioner.

I am the president of my own company, which is an insurance agency providing various forms of insurance coverage for credit unions and their members. A big part of my business is in the marketing of creditor life and disability insurance. Over the years we have had the opportunity of meeting with Ms. Khachadour and Mr. John Fog, Legal Counsel for the Department. As a result of these meetings and conversations with the Department, I feel the Department has shown a complete lack of consistency and has been totally ignorant of the over-all effects of hearing decisions and regulations. The Department (Ms. Khachadour) has consistently shown favoritism to much larger influencial companies and has repeatedly ignored the smaller enterprises, such as my own. These decisions have placed my company in the position of signing its demise or attacking the validity of the inconsistencies and mismanagement of the hearing decisions. At the present time, we are considering a legal course of action against the Department and Ms. Khachadour.

I believe that Officers of the State are in a responsible position and should hear all views of interested parties and make a final determination that is in the best interest of everyone. I could elaborate endlessly and provide documentation on many issues, but I do not feel that is the real purpose of writing you.

I seek no remedy to my problem through legislation, but feel I have a responsibility to inform you of the complete lack of understanding, impartiality, and fairness to the consumer insured and agencies such as mine.

Sincerely yours,

INC.

President

/ca